

FILED AUG 1 - 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

DR. HORST

21825

State File No.

BIRTH NO. REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 651

1. PLACE OF DEATH a. COUNTY <u>GREENE</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE <u>MISSOURI</u> b. COUNTY <u>GREENE</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>SPRINGFIELD</u>		c. CITY OR TOWN <u>SPRINGFIELD</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>2 1/2</u> a.		No. STREET ADDRESS (If rural, give location) <u>733 S. GLENSTONE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>D.O.A. ST. JOHN'S HOSP.</u>			

3. NAME OF DECEASED (Type or Print) <u>JAMES A. MACDONNELL</u>			4. DATE OF DEATH <u>JULY 28 1955</u>		
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	
8. DATE OF BIRTH <u>APRIL 21 1886</u>		9. AGE (In years last birthday) <u>69</u>		IF UNDER 21 YEARS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SPELD. TABLET CO.</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>HOLYOKE, MASS.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					

13a. FATHER'S NAME <u>JOHN T.F. MACDONNELL</u>		13b. MOTHER'S MAIDEN NAME <u>MARY MARTIN</u>		14. NAME OF HUSBAND OR WIFE <u>BEATRICE HUTCHINS</u>	
15. WAS DECEASED EVER IN U.S. ARMED SERVICES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT'S SIGNATURE OR NAME <u>MRS. BEATRICE MACDONNELL</u> ADDRESS <u>SPELD. MO.</u>	

18. CAUSE OF DEATH - Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Vessel disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years 9 months</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Arteriosclerosis</u>		<u>2 years 9 months</u>	
DUE TO (c) <u>4200</u>		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct 16, 1952, to July 28, 1955, that I last saw the deceased alive on July 27, 1955, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>O.E. Horst M.D.</u> (Degree or title)		23b. ADDRESS <u>430 South Ave Springfield Mo</u>		23c. DATE SIGNED <u>July 28 1955</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>8/1/55</u>		24c. NAME OF CEMETERY OR CREMATORY <u>EASTLAWN</u>	
24d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD, MO.</u>		25. JUNE 1955 REGISTRAR'S SIGNATURE <u>Earl Williams</u> ADDRESS <u>SPRINGFIELD, MO.</u>			
DATE REC'D BY LOCAL REG. <u>7-29-55</u>					

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

1906 08 11

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

by me, or by, Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Gene C. Hunter*

Licensed Embalmer No. *473*

P. O. Address *Springfield*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.