

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **25606**

FILED AUG 14 1956

BIRTH NO. _____		REG. DIST. NO. <u>317</u>		PRIMARY REG. DIST. NO. <u>500</u>		Registrar's No. <u>1391</u>	
1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY _____			
b. CITY (If <u>unincorporated</u> and give town) OR TOWN <u>RURAL North County</u>		c. LENGTH OF STAY (in this place) <u>3 mos.</u>		c. CITY OR TOWN <u>NEW ATHENS</u>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ULLABY NURSERY, 10069 BON OAK</u>				e. STREET ADDRESS (If rural, give location) <u>RURAL ROUTE II 8178</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>DAVID</u> b. (Middle) <u>-</u> c. (Last) <u>MCDONOUGH</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 25 1956</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>FEB. 29, 1926</u>	
9. AGE (In years last birthday) <u>45</u>		IF UNDER 1 YEAR Months <u>26</u> Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>ALTON, ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13a. FATHER'S NAME <u>BERNELL MCDONOUGH</u>			13b. MOTHER'S MAIDEN NAME <u>DONA MCDONOUGH</u>			14. NAME OF HUSBAND OR WIFE <u>NONE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>DONA MCDONOUGH</u> ADDRESS <u>NEW ATHENS, ILL.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Bronchial Pneumonia</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 Hrs</u> ANTECEDENT CAUSES DUE TO (b) <u>Chronic Bronchial Infection</u> <u>3 Months</u> DUE TO (c) _____ Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. 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) <u>491X</u>			
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 <u>3-15-56</u> , 19 <u>56</u> , to <u>4-24-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>4-24-56</u> , 19 <u>56</u> , and that death occurred at <u>4:15A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>[Signature]</u> (Degree or title) <u>Dr.</u>				23b. ADDRESS <u>330 N. Frances, Florissant</u>		23c. DATE SIGNED <u>7-26-56</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>7-26-56</u>		24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL Park</u>		24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, Mo.</u>	
DATE REC'D BY LOCAL REG. <u>7-26-56</u>		REGISTRAR'S SIGNATURE <u>Herbert R. Donohue</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Gene A. Stillness</u> ADDRESS <u>FLORISSANT, MO.</u>			

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

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 A. Litchens*.....

Licensed Embalmer No. *4966*

P. O. Address *Blount*.....

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.