

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

**7696**

STATE FILE NUMBER

**FILED APR 15 1957**

42

1000

390

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Buchanan</b> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>2310 S. 12th St.,</b>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b> c. CITY OR TOWN <b>St. Joseph 01170</b> d. STREET ADDRESS <b>2310 S. 12th St.,</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
Length of stay in lb <b>22 years</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

<b>3. NAME OF DECEASED</b> (Type or print) First <b>AUSTIN</b> Middle <b>P.</b> Last <b>MC DONELL</b>			<b>4. DATE OF DEATH</b> Month <b>April</b> Day <b>8</b> Year <b>1957</b>				
<b>5. SEX</b> male <input checked="" type="checkbox"/>	<b>6. COLOR OR RACE</b> white	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	<b>8. DATE OF BIRTH</b> Oct. 9, 1886	<b>9. AGE</b> (In years last birthday) 70	<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hour _____ Min. _____	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) carpenter		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (City and state or country) Adam County, Nebr.		<b>12. CITIZEN OF WHAT COUNTRY?</b> USA	
<b>13. FATHER'S NAME</b> Randall McDonell			<b>14. MOTHER'S MAIDEN NAME</b> Mary Brennan				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) yes <b>W.W. #1</b>		<b>16. SOCIAL SECURITY NO.</b> 491-24-5333		<b>17. INFORMANT</b> Mrs. James Miller, 2822 So. 12th St. Joseph, Mo.			

<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE - (a) <b>Hepatic coma</b> DUE TO (b) <b>Haemorrhagic Birehosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 3 days 3 months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

<b>20a. ACCIDENT</b> <input type="checkbox"/>	<b>SUICIDE</b> <input type="checkbox"/>	<b>HOMICIDE</b> <input type="checkbox"/>	<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)		
<b>20c. TIME OF INJURY</b> Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____			_____		
<b>20d. INJURY OCCURRED</b> WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (e. g., in or about home, farm, factory, street, office bldg., etc.)		<b>20f. CITY, TOWN, OR LOCATION</b> COUNTY STATE	

21. I attended the deceased from **1-14-57** to **4-8-57** and last saw her/him alive on **4-7-57**  
 Death occurred at **9:40 p.m.** on the date stated above; and to the best of my knowledge, from the causes stated.

<b>22a. SIGNATURE</b> Richard L. Maguire M.D.	<b>22b. ADDRESS</b> Phys & Surg Bldg 216, City	<b>22c. DATE SIGNED</b> 4-9-57
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<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> burial	<b>23b. DATE</b> 4/12/1957	<b>23c. NAME OF CEMETERY OR CREMATORY</b> Ashland Cemetery	<b>23d. LOCATION (City, town, or county)</b> (State) St. Joseph, Mo.
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<b>24. FUNERAL DIRECTOR</b> ADDRESS Nestor Bowman St Joseph Mo	<b>25. DATE RECD. BY LOCAL REG.</b> April 11, 1957	<b>26. REGISTRAR'S SIGNATURE</b> Esther M. Allison
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(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related. Coroner cannot certify to a death due to natural causes. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

*W. Morgan B. Reed*

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 *William Spalding*.....

Licensed Embalmer No. *453*

P. O. Address *3195 10th St*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.