

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **33419**
8122
Registrar's No.

FILED SEP 17 1957

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH
a. COUNTY _____ 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE _____ b. COUNTY _____

b. CITY OR TOWN **St. Louis** c. LENGTH OF STAY (In this place) **3 yrs. 2 mo** c. CITY OR TOWN **St. Louis** d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF HOSPITAL OR INSTITUTION **St. Louis Chronic Hosp.** STREET ADDRESS (If rural, give location) **2160a Salisbury**

3. NAME OF DECEASED a. (First) **Mary** b. (Middle) _____ c. (Last) **Donne** 4. DATE OF DEATH (Month) (Day) (Year) **8-28-1957**

5. SEX **female** 6. COLOR OR RACE **white** 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) **widow** 8. DATE OF BIRTH **Oct. 30, 1878** 9. AGE (In years last birthday) **78 yrs** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Housewife** 10b. KIND OF BUSINESS OR INDUSTRY _____ 11. BIRTHPLACE (City and State or Foreign Country) **Ill.** 12. CITIZEN OF WHAT COUNTRY? **U.S.A.**

13a. FATHER'S NAME **Benjamin Hecker** 13b. MOTHER'S MAIDEN NAME **unk.** 14. NAME OF HUSBAND OR WIFE **Henry Clay Donne**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** 16. SOCIAL SECURITY NO. _____ 17. INFORMANT'S SIGNATURE OR NAME **Mrs. Molkenbur** ADDRESS **3916 N. 20th St.**

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
MEDICAL CERTIFICATION
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Bilateral Hypostatic Pneumonia** INTERVAL BETWEEN ONSET AND DEATH **2 days**
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) **Cerebral Thrombosis** **3 days**
DUE TO (c) **Left Hemiplegia + Epilepsy**
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. **Generalized Arteriosclerosis** **3 yrs**

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION _____ 20. AUTOPSY? YES NO

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) **332x**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from **6-24-54**, 19____, to **8-28-57**, 19____, that I last saw the deceased alive on **8-28-57**, 19____, and that death occurred at **11:00 p.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) **John W. Beckham, M.D.** 23b. ADDRESS **5800 Arsenal St.** 23c. DATE SIGNED **8/29/57**

24a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 24b. DATE **8/31/57** 24c. NAME OF CEMETERY OR CREMATORY **Calvary Cemetery** 24d. LOCATION (City, town, or county) (State) **St. Louis Mo.**

DATE REC'D BY LOCAL REG. **AUG 30 57** REGISTRAR'S SIGNATURE **J. Carl Smith M.D.** FUNERAL DIRECTOR'S SIGNATURE ADDRESS **Robert D. Kinney 2228 St. Louis**

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 *Homer W. Kelly*.....

Licensed Embalmer No. *388*

P. O. Address *St. Louis, Mo.*

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.