

Health,  
& Welfare  
S. Public  
th Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41914  
STATE FILE NUMBER

FILED DEC 9 - 1957

Registration District No. 318 Primary Registration District No. 1003

Registrar's No. 10554

300  
57

1. PLACE OF DEATH a. COUNTY <b>St. Louis</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>Florissant</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Christian Hospital</b>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <b>700 Crowder Lane</b>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Stephen</b> Middle <b>Wayne</b> Last <b>Donahue</b>			4. DATE OF DEATH Month <b>Oct.</b> Day <b>31</b> Year <b>1957</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 31, 1957</b>		9. AGE (In years last birthday) IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Mins <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13a. FATHER'S NAME <b>James M. Donahue</b>		13b. MOTHER'S MAIDEN NAME <b>L. Mary Strange</b>		14. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>James M. Donahue</b> Address: <b>Florissant, Mo. 700 Crowder</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fr ematurity</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (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)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>77bx</b>			
20c. TIME OF INJURY Hour _____ Month, Day, Year _____ a.m. _____ p.m. _____					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <b>10-31-57</b> to <b>10-31-57</b> and last saw her alive on <b>10-31-57</b> Death occurred at <b>7:44 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <b>W.D. Bishop</b> (Degree or title)		22b. ADDRESS <b>Florissant, Mo.</b>		22c. DATE SIGNED <b>14 Nov 57</b>	
23a. BURIAL OR CREMATION REMOVAL (Specify)		23b. DATE <b>11-30-57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board City of St. Louis</b>		23d. LOCATION (City, town, or county) (State) <b>Anatomical Board St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Rowland-Aker</b>		ADDRESS <b>4104 Manchester</b>		25. DATE RECD. BY LOCAL REG. <b>11-7-57</b>	26. REGISTRAR'S SIGNATURE <b>Carl Smith MO mjs</b>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

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.

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 .....

Signed .....

Signature of Student Embalmer

FR-12-01

FR-12-01

FR-12-01

Licensed Embalmer No. ....

P. O. Address .....

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: FR-12-01

If this body is not embalmed, fact should be so stated above.