

FILED JAN 7 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH46799
STATE FILE NUMBERRegistration District No. 317 Primary Registration District No. 500 Registrar's No. 3216

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Manchester</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>DesPeres</u> <u>4000</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Manchester Nursing</u>			Length of stay in 1b <u>6 wks.</u>		d. STREET ADDRESS <u>R#13 Box#257</u>		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Mabel</u> Middle <u>Catherine</u> Last <u>Donovan</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>18</u> Year <u>1957</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Mar. 2, 1895</u>		9. AGE (In years last birthday) <u>62</u>	
						IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (City and state or country) <u>Terre Haute, Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Ogletree</u>				14. MOTHER'S MAIDEN NAME <u>Laurina Smith</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Robert L. Donovan, Chesterfield, Mo.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Streptococcic Sore Throat</u>								INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
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) <u>Heniplegia</u>								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.)						
20c. TIME OF INJURY Hour _____ 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 <u>Manchester, Mo.</u>		COUNTY		STATE	
21. I attended the deceased from <u>Dec. 8, '57</u> to <u>Dec. 18, '57</u> and last saw her/him alive on <u>Dec. 18, '57</u> Death occurred at <u>11:50 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Ralph W. Laffey, D.O.</u>				22b. ADDRESS <u>Manchester, Mo.</u>				22c. DATE SIGNED <u>12/19/57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>12-20-1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>St. Ann, Missouri</u>			
24. FUNERAL DIRECTOR <u>Baumann Bros. Inc.</u> <u>2504 Woodson Rd., Overland, Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-19-57</u>		26. REGISTRAR'S SIGNATURE <u>Herbert R. Donke, MD</u>			

(Licensed Embalmer's Statement on Reverse Side)

Health & Welfare
Public
Service300
1-56

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

MEDICAL CERTIFICATION

acc

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 *David C. Gibson*

Licensed Embalmer No. *34*

P. O. Address *Portland*

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.