

FILED FEB 6 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

3255

STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 888

300
-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS Mo</u>		c. CITY OR TOWN <u>ST. LOUIS</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>3426^a ALBERTA</u>		d. STREET ADDRESS (If outside, give location). <u>3426^a ALBERTA</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DONALD McDERMOTT</u>		4. DATE OF DEATH Month Day Year <u>JAN. 22 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 17 1956</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>2</u>
11. BIRTHPLACE (City and state or country) <u>Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13a. FATHER'S NAME <u>DONALD McDERMOTT</u>		13b. MOTHER'S MAIDEN NAME <u>MARY McLAUGHLIN</u>	
14. NAME OF HUSBAND OR WIFE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service)	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DONALD McDERMOTT</u> Address <u>3426 ALBERTA</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>Influenza (intestinal)</u> 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>482x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
19a. 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 Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <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 <u>1-20-58</u> to <u>1-22-58</u> and last saw ^{her} _{him} alive on <u>1-20-58</u> Death occurred at <u>9:30 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>God Castello MD</u>		22b. ADDRESS <u>4952 Maryland</u>	
22c. DATE SIGNED <u>1/24/58</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL JAN. 25 1958</u>	
23b. DATE <u>JAN. 25 1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RESURRECTION CEM.</u>	
23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS Mo</u>		24. FUNERAL DIRECTOR <u>Thomas Ruten 2906 Gravier</u>	
25. DATE RECD. BY LOCAL REG. <u>JAN 24 '58</u>		26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u>	

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

10-12 am Friday
1112

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 *Leo J. Buddle*
Licensed Embalmer No. *3989*
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.