

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-042541

STATE FILE NUMBER

NOV 18 1958

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 2936

300
1-57

1. PLACE OF DEATH a. COUNTY <u>County St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>ST LOUIS</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>	Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>KINLOCH 40910</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST LOUIS COUNTY HOSP 5 days</u>	Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>1276 BOOKER AVE</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Andrew</u> Middle _____ Last <u>McDonald</u>			4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>58</u>			
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5. SEX <u>MALE</u>	6. COLOR OR RACE <u>2 NEGRO</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>8-10-1886</u>	9. AGE (In years last birthday) <u>72</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and state or country) <u>MERIDIAN MISS</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>POMPIE MCDONALD</u>	13b. MOTHER'S MAIDEN NAME <u>MATTIE CORATHERS</u>	14. NAME OF HUSBAND OR WIFE
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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>718-03-9194</u>	17. INFORMANT <u>Mrs David Loyd</u>	Address <u>300 A BRIDGE</u>
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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>Cerebral vascular accident</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Cerebral atherosclerosis</u>	
	DUE TO (c) <u>331XH</u>	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Carcinoma of stomach & metastasis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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.)
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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 _____
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21. I attended the deceased from <u>9-7-58</u> to <u>11-11-58</u> and last saw her alive on <u>11-11-58</u> Death occurred at <u>4:45</u> <u>A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.
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22a. SIGNATURE (Degree or title) <u>Vincent J. Fiedrich MD</u>	22b. ADDRESS <u>601 So. Brentwood</u>	22c. DATE SIGNED <u>11/11/58</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>NOV 17 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>WASHINGTON PARK CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County MO.</u>
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24. FUNERAL DIRECTOR <u>PRICE FUNERAL HOME</u>	ADDRESS <u>2829 Washington</u>	25. DATE RECD. BY LOCAL REG. <u>11/12/58</u>	26. REGISTRAR'S SIGNATURE <u>Nervert R. Donke Jr. D</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be only standard nomenclature in full to: 10 symptoms will be 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 _____
Signature of Student Embalmer

Signed Gayton Swan _____

Licensed Embalmer No. 4580.....

P. O. Address 4202 Finney.....

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.