

Health,  
Welfare  
Public  
Service

300  
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

*D. Well*

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-044919

STATE FILE NUMBER

FILED DEC 29 1958

Registration District No. 209 Primary Registration District No. 4320 Registrar's No. 38

1. PLACE OF DEATH a. COUNTY <u>Marion</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Marion</u>					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Palmyra</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>Palmyra</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			Length of stay in 1b		d. STREET ADDRESS (If outside, give location) <u>620 N. Main</u>			Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>M.</u> Last <u>Donelson</u>				4. DATE OF DEATH Month <u>12</u> Day <u>7</u> Year <u>1958</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/1874</u>		9. AGE (In years last birthday) <u>84</u> IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Highway Dept</u>		11. BIRTHPLACE (City and state or country) <u>Loudenville Ohio</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Calvin Donelson</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Adame</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>498-34-9769-A</u>		17. INFORMANT <u>Mrs. C. M. Donelson</u> Address <u>Palmyra 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>Bronchial pneumonia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Arterio sclerosis advanced</u> DUE TO (c) <u>Senile dementia</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 da.</u> <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>334x</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 <u>    </u> Month, Day, Year a. m. <u>    </u> p. m. <u>    </u>									
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 <u>1956</u> to <u>12/7/58</u> and last saw her alive on <u>12/6/58</u> Death occurred at <u>8 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>[Signature]</u> (Deceased or title)				22b. ADDRESS <u>Palmyra Mo.</u>				22c. DATE SIGNED <u>12/9/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>12/10/1958</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Palmyra Mo.</u>			
24. FUNERAL DIRECTOR ADDRESS <u>E.T. Sprague Palmyra Mo.</u>				25. DATE RECD. BY LOCAL REG. <u>12-11-58</u>		26. REGISTRAR'S SIGNATURE <u>[Signature]</u> <u>By Thela Green Deputy</u>			

(Licensed Embalmer's Statement on Reverse Side)

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RECEIVED

DEC 27 1958

MARION CO. HEALTH DEPT.

DATE FILED

DEC 27 1953

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..... *E. J. Sprague*.....

Licensed Embalmer No. 3245

P. O. Address..... Palmyra, M.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.