

RI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-027559

FILED VS AUG 17 1959

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2152 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY St. Louis				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights		Length of stay in lb 5 Hrs.		c. CITY OR TOWN Maplewood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 7353 Gayola Pl.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FREIDA Middle NMI Last DONALDSON				4. DATE OF DEATH Month August Day 8 Year 1959			
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1-13-1894	9. AGE (last birthday) 65	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (City and state or country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Michael Madison			13b. MOTHER'S MAIDEN NAME Margaret Schroader			14. NAME OF HUSBAND OR WIFE William Donaldson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 377-16-7482		17. INFORMANT William Donaldson, above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Cerebral arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 4 hours 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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. Month, Day, Year _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 Jan 27 1952 to 8-8-59 and last saw her/him alive on 8-8-59 Death occurred at 9:00 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE Paul T. Hartman MD (Degree or title)				22b. ADDRESS 6376 Clayton Rd			22c. DATE SIGNED 8-10-59
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-12-1959	23c. NAME OF CEMETERY OR CREMATORY New St. Marcus Cemetery		23d. LOCATION (City, town, or county) St. Louis Co., Mo.		(State)
24. FUNERAL DIRECTOR JAY B. SMITH, Maplewood, Mo. ADDRESS				25. DATE RECD. BY LOCAL REG. 8-11-59		26. REGISTRAR'S SIGNATURE John C. Murphy MD	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

J. Allen Davis

Licensed Embalmer No. 4057

P. O. Address St. Louis

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.