

IRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-030351

FILED VS AUG 31 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **2 7413** STATE FILE NUMBER

INDEXED

| | | | | | | | |
|---|---|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis, Missouri Length of stay in 1b _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis c. CITY OR TOWN Sappington Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) P.O. Box 41 Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First JAMES Middle E. DONALLY Last _____ | | | 4. DATE OF DEATH Month August Day 8 Year 1959 | | | | |
| 5. SEX Male | 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 3-23-1892 | 9. AGE (last birthday) 67 | IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HR Hours _____ Min. _____ | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Spring Manf. | | 11. BIRTHPLACE (City and state or country) New York, N.Y. | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13a. FATHER'S NAME Melvin E. Donally | | 13b. MOTHER'S MAIDEN NAME Amalia Miner | | 14. NAME OF HUSBAND OR WIFE Dorothy Williams Donally | | | |
| 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. 489-01-7959 | | 17. INFORMANT Address P.O. Mrs. D.L. Donally Sappington, Mo. Box 41 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 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) _____ PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 hours | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 February 28, 1959 to August 8, 1959 and last saw him live on August 8, 1959 Death occurred at 11:45 p.m. <input checked="" type="checkbox"/> on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE Crest T. Rouse (Degree or title) M. D. | | | 22b. ADDRESS Barnes Hospital | | 22c. DATE SIGNED 8/9/59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) removal | | 23b. DATE 8-12-59 | | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Mausoleum | | | |
| 23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo. | | 24. FUNERAL DIRECTOR C.R. Lupton & Sons ADDRESS 7233 Delmar Blvd. | | | | | |
| 25. DATE RECD. BY LOCAL REG. AUG 10 '59 | | | 26. REGISTRAR'S SIGNATURE Earl Smith, M.D. | | | | |

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 Donald W. Rhoads

Licensed Embalmer No. 3864

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.