

PURVIS DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 12 1959

59-037832

210054

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN 915 N GRAND ST LOUIS MO		Length of stay in 1b 3 DAYS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VETS ADMIN HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AUGUST Middle C. Last MC DONALD		4. DATE OF DEATH Month OCTOBER Day 31 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 7/16/1893
9. AGE (last birthday) 60-66		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PRINTER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (City and state or country) MILWAUKEE, WIS.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME RICHARD MC DONALD		13b. MOTHER'S MAIDEN NAME EMILY MARTIN	
14. NAME OF HUSBAND OR WIFE CHARLOTTE M MC DONALD		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO. 393-03-9626		17. INFORMANT Address VA HOSP RECORDS 915 N GRAND ST LOUIS MO.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ORTHOSTATIC PNEUMONIA DUE TO (b) CARCINOMA OF THE ESOPHAGUS DUE TO (c) 150 X 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 1 WEEK 8 MO.
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 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	
21. I attended the deceased from 10/28/59 to 10/31/59 and last saw him alive on 10/31/59 Death occurred at 11:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE H. L. Ellis (Degree or title) M.D.		22b. ADDRESS VAH, ST LOUIS, MISSOURI	
22c. DATE SIGNED 10-31-59		23a. BURIAL, CREMATION, REMOVAL (Specify) removal	
23b. DATE 11/4/1959		23c. NAME OF CEMETERY OR CREMATORY National Cemetery	
23d. LOCATION (City, town, or county) St. Louis Co., Mo.		24. FUNERAL DIRECTOR John L Ziegenhein & Sons 7027 Gravois	
25. DATE RECD. BY LOCAL REG. NOV 2 1959		26. REGISTRAR'S SIGNATURE Earl Smith M.D.	

11/12/59

DOCUMENT Baptismal Record 7/2/1893

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BY AFFIDAVIT OF Funeral Director

MEDICAL CERTIFICATION

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M.D.

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

C. P. Kidwell

Licensed Embalmer No. 3877

P. O. Address 7027 Straus

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.