

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-041760

FILED VS. NOV. 20 1959

210212

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>ST. LOUIS Mo</i>		Length of stay in 1b	c. CITY OR TOWN <i>ST. LOUIS</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>ST. LOUIS CITY HOSP.</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <i>3745 MERAMEC</i>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>WILLIAM A. DONOVAN</i>			4. DATE OF DEATH Month Day Year <i>Nov. 3 1959</i>			
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <i>JULY 29 1886</i>	9. AGE (last birthday) <i>73</i>	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) <i>RETIRED SWITCHMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>TERMINAL R.R.</i>	11. BIRTHPLACE (City and state or country) <i>IOWA</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13a. FATHER'S NAME <i>JOHN DONOVAN</i>		13b. MOTHER'S MAIDEN NAME <i>UNKNOWN</i>		14. NAME OF HUSBAND OR WIFE <i>AGNES DONOVAN</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES WAR I</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT Address <i>AGNES DONOVAN 3745 MERAMEC</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fractured pelvis</i> DUE TO (b) <i>New marriage</i> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the immediate disease condition given in PART I (a) <i>I suffered when struck by car operated by unknown party, at Grand and Gasconade about 900 p.m., November 3, 1959</i> 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	
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, if any, in Part I of item 18.) <i>Struck by car operated by unknown party, at Grand and Gasconade about 900 p.m., November 3, 1959</i>				
20c. TIME OF INJURY Hour <i>900</i> p.m. Month, Day, Year <i>11 3 59</i>		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.) <i>Street</i>	20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>		
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____. Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <i>John M. Smith</i>		22b. ADDRESS <i>1300 Chest</i>		22c. DATE SIGNED <i>11/4/59</i>		
23. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	23b. DATE <i>Nov. 9 1959</i>	23c. NAME OF CEMETERY OR CREMATORY <i>CALVARY CEM.</i>		23d. LOCATION (City, town, or county) (State) <i>ST. LOUIS Mo</i>		
24. FUNERAL DIRECTOR <i>Thomas Kutes 2906 Gravois</i>		25. DATE RECD. BY LOCAL REG. <i>NOV 6 1959</i>	26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>			

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 me
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

James C. Hill

Licensed Embalmer No. 43471

P. O. Address 2906 Da

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.