

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS MAR 3 1 1960

2 3214 **60-012910**
STATE FILE NUMBER

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

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI | | Length of stay in 1b 10 DAYS | c. CITY OR TOWN ST. LOUIS |
| c. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 6661 BANCROFT |
| Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | | |

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|--|--------------------------------------|---|--|---|--------------------------------|---|
| 3. NAME OF DECEASED (Type or print) First Middle Last JAMES C. McDONALD | | | 4. DATE OF DEATH Month Day Year MARCH 19 1960 | | | |
| 5. SEX MALE | 6. COLOR OR RACE CAUCASTAN | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 12/25/1901 | 9. AGE (last birthday) 58 | 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) Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY Refrigeration | | 11. BIRTHPLACE (City and state or country) ROFF, OKLAHOMA | | 12. CITIZEN OF WHAT COUNTRY USA |

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|---|--|---|--|---|--|
| 13a. FATHER'S NAME AUSTIN McDONALD | | 13b. MOTHER'S MAIDEN NAME SELA VELMA HACKER | | 14. NAME OF HUSBAND OR WIFE DORTHA E. McDONALD | |
| 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. 494 05 9170 | | 17. INFORMANT DORTHA E. McDONALD, 6661 BANCROFT | |

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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA | | | 8-10 HOURS |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) CARCINOMA OF PROSTATE WITH GENERALIZED METASTASES | | 2 YEARS |
| | DUE TO (c) 177x | | |

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| 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 | | |
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|--|---|--|--------|-------|--|
| 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 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 **JULY 2, 1948** to **MARCH 19, 1960** and last saw her/him alive on **MARCH 19, 1960**
Death occurred at **3:25 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>C. D. Hamilton M.D.</i> | (Degree or title) M. D. | 22b. ADDRESS BARNES HOSPITAL | 22c. DATE SIGNED 3/19/60 |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | 23b. DATE 3/20/1960 | 23c. NAME OF CEMETERY OR CREMATORY MEMORIAL CEMETERY | 23d. LOCATION (City, town, or county) EDMOND, OKLAHOMA |
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| 24. FUNERAL DIRECTOR HOFFMEISTER COLONIAL MORTUARY 6464 CHIPPEWA STREET, ST. LOUIS, MO. | 25. DATE RECD. BY LOCAL REG. MAR 19 1960 | 26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i> MS |
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DOCUMENT
MEDICAL CERTIFICATION
BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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 John Shenn
Licensed Embalmer No. 419
P. O. Address St. Louis

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