

# JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-013497

FILED VS MAR 3 0 1960

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 548 Registrar's No. 719

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Webster Groves Mo.</u>	Length of stay in 1b <u>clays</u>	c. CITY OR TOWN <u>Augusta</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Glenwood San.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>R.R. #1</u>

3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Wilson</u> Last <u>DONALDSON</u>	4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1960</u>
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5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-5-1885</u>	9. AGE (last birthday) <u>74</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manufacturer (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Cooperage</u>	11. BIRTHPLACE (City and state or country) <u>Aussein, Indiana</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Robert Donaldson</u>	13b. MOTHER'S MAIDEN NAME <u>Elizabeth Vail</u>	14. NAME OF HUSBAND OR WIFE <u>Mayme A. Donaldson</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>	16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMATION <u>Kirkwood 22, Missouri</u> <u>Mrs. Wm. Goodall 406 Central Pl.</u>
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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: IMMEDIATE CAUSE (a) <u>coronary embolism</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 minute</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>cardiac insufficiency</u>		<u>2 days</u>
DUE TO (c) <u>rt. lobar pneumonia</u>		<u>5 days</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>arteriosclerotic heart disease, generalized arteriosclerosis</u>	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
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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.)
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20c. TIME OF INJURY Hour _____ Month, Day, Year _____ p.m.
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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
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21. I attended the deceased from 12-20-57 to 3-1-60 and last saw her alive on 3-1-60  
Death occurred at 3-1-60 3 PM on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Thomas J. Flynn M.D.</u>	22b. ADDRESS	22c. DATE SIGNED <u>3-2-60</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>March 3, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis County Missouri.</u>
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24. FUNERAL DIRECTOR <u>C.R. Lupton and Sons 7233 Delmar Blv'd.</u>	25. DATE RECD. BY LOCAL REG. <u>3-2-60</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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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 Arnold W. Schoen

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.