

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-032397

318 1003

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

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

8401

VS 300 Rev. 4/59
1
Hors, 3
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4 0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. **FILED** SEP 10 1962
 a. COUNTY **ST. Louis**
 b. CITY (If outside corporate limits, give TOWNSHIP only) **ST. Louis** Length of stay in 1b
 c. CITY OR TOWN **Affton** Inside Limits Yes No
 c. FULL NAME OF (If NOT in hospital, give location) **ST. Anthony's Hospital** Inside Limits Yes No d. STREET ADDRESS (If outside, give location) **8538 General Grant Home** Reside on Farm Yes No

3. NAME OF DECEASED First **Alphonse** Middle **Louis** Last **Donley** 4. DATE OF DEATH Month **Aug.** Day **28** Year **1962**

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married Widowed Divorced 8. DATE OF BIRTH **Dec. 29, 1905** 9. AGE (last birthday) **56** IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HR

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Salesman** 10b. KIND OF BUSINESS OR INDUSTRY **Wellingburg Carpet Co.** 11. BIRTHPLACE (City and state or country) **ST. Louis, Mo.** 12. CITIZEN OF WHAT COUNTRY **U.S.A.**

13a. FATHER'S NAME **George Donley** 13b. MOTHER'S MAIDEN NAME **Fdg Jacob** 14. NAME OF HUSBAND OR WIFE **Theresa Donley**

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. 17. INFORMANT **Theresa Donley** Address **Affton, 8538 General Grant Home**

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Post Surgical atelectasis** INTERVAL BETWEEN ONSET AND DEATH **6hr**
 Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) **Carcinoma of esophagus c** **6 months**
 DUE TO (c) **metastasis 150x**

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. Yes N. Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. ACCIDENT SUICIDE HOMICIDE 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
 20d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 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 **7-9-54** to **8-28-62** and last saw him alive on **8-28-62**
 Death occurred at **8:15 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **Dr. W. J. Jorman M.D.** 22b. ADDRESS **9501 Quivora** 22c. DATE SIGNED **8-28-62**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **Aug. 31, 1962** 23c. NAME OF CEMETERY OR CREMATORY **Resurrection Cemetery** 23d. LOCATION (City, town, or county) (State) **ST. Louis, Mo.**

24. FUNERAL DIRECTOR **Will Mortuary** ADDRESS **6409 Gravois Ave.** 25. DATE RECD. BY LOCAL REG. **AUG 29 1962** 26. REGISTRAR'S SIGNATURE **Loard Smith, M.D.**

USE BLACK INK OR TYPEWRITER RIBBON

DR. FORSMAN
9505 GRAVOIS

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 Stanley H. Dixon

Licensed Embalmer No. 4193

P. O. Address St. Louis, Mo.

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.