

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-042582

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

5864 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 5864

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>OHIO</u> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		Length of stay in lb <u>3 days</u>	c. CITY OR TOWN <u>AKRON</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>SAINT LUKE'S</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>848 CARROLL</u> Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>S.</u> Last <u>DONAHUE</u>		4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>62</u>	
5. SEX <u>FEMALE</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>8-17-1884</u> 9. AGE (last birthday) <u>78</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and state or country) <u>Byesville, Ohio</u> 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13a. FATHER'S NAME <u>James R. Watson</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>John T. Donahue</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Michael J. Donahue, 1855 Manchester Rd., Akron, Ohio</u>
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>Cerebral Embolus</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Auricular Fibrillation</u> DUE TO (c) <u>Rheumatic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>65 days</u> <u>Indefinite</u>
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
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 _____ Month, Day, Year _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" 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 <u>11-6-62</u> to <u>11-21-62</u> and last saw ^(her) <u>him</u> alive on <u>11-21-62</u> Death occurred at <u>10:55 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Samuel C. Petrie MD</u>		22b. ADDRESS <u>6100 Martway Mission, Kansas</u>	22c. DATE SIGNED <u>11-21-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>11-21-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>	23d. LOCATION (City, town, or county) <u>Akron, Ohio</u>
24. FUNERAL DIRECTOR ADDRESS <u>Stine & McClure, Kansas City, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>11-21-62</u>	26. REGISTRAR'S SIGNATURE <u>Oruth Long</u>

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

Samuel C. Petrie

MEDICAL CERTIFICATION

USE BLACK INK OR TYPEWRITER RIBBON

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 Wm. M. Turner

Licensed Embalmer No. 4648

P. O. Address K C

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.