

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

Form 1 X1951

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

Registration District No. 784 Primary Registration District No. 109 Registrar's No. 2165

1. PLACE OF DEATH:
 (a) County St. Louis 3
 (b) City or town Maplewood
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Maplewood Nursing Home 2200 Bredell
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution One month
 In this community Unknown (Specify whether years, months or days)

3. (a) PRINT FULL NAME Susan Donnelly 540
 3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
 6. (b) Name of husband or wife Joseph Donnelly deceased 6. (c) Age of husband or wife if alive ----- years
 7. Birth date of deceased July 22, 1872
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 4 15 hr. min.

9. Birthplace Elkhorn, Ills.
 (City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business

12. Name James Cunningham

13. Birthplace Illinois
 (City, town, or county) (State or foreign country)

14. Maiden name Dehlia Roundtree

15. Birthplace Illinois
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs James T Cook

(b) Address 5536 Robin Ave

17. (a) Burial (b) Date thereof 12-9-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Math Hermann & Son

(b) Address 2161 East Fair Ave

19. (a) DEC 9 - 1939 (b) [Signature]
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County 1
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL")
 (d) Street No. 3018 Easton Ave
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 7th
 year 1939 hour 6:20 PM minute _____ M.

21. I hereby certify that I attended the deceased from Nov. 7th, 1939 to Dec 7th, 1939
 that I last saw him alive on Dec 5th, 1939
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic pneumonia Duration _____

Due to Old age and chronic Endocarditis

Other conditions Paresis of Brain
 (Include pregnancy within 9 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 PHYSICIAN _____
 Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____ (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) Means of injury _____

23. Signature [Signature] (M. D. or other) _____
 Address 7465 Hazel Ave Date signed 12-8-39

52

1907

1907

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.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed *Henry Hampton*

Licensed Embalmer No. 2967

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 this body is not embalmed, above space should be left blank.

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County St. Louis

Registration District No. 784

File No. 44637

Township

Primary Registration District No. 109

Registered No. 2165

City Maplewood

(No. M. Nursing Home)

St. _____ Ward _____

2. FULL NAME

Susan Donnelly

(a) Residence, No. _____ St. _____ Ward _____
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or mins.
67 4 15

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) _____
11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

FATHER
13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER
15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. UNDERTAKER (ADDRESS)

20. FILED _____ 19 _____

Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec. 7 1924

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Hypostatic pneumonia
Old age - Chron. Endocarditis
Paresis of brain

Other contributory causes of importance:

Senile g. d. w.

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

(Signed) Theo. F. Kiel _____, M. D.

(Address) 7465 Hazel Ave.

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