

S. No. 2  
1-2.43  
5-17-39  
P-1 X35697

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED NOV 1 1943**

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

33039

State File No. \_\_\_\_\_

9399

Registrar's No. \_\_\_\_\_

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County **St. Louis**  
(b) City or town **St. Louis**  
(c) Name of hospital or institution: **De Paul Hosp.**  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Missouri** (b) County **St. Louis**  
(c) City or town **St. Louis**  
(d) Street No. **4986 Rosalie Ave.**  
(e) Citizen of foreign country? **0** (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME **Catherine Donovan**  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. **None**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **25**  
year **1943** hour **2** minute **30** A. M.

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married. **Divorced Widow**  
6. (b) Name of husband or wife **John B. Donovan** 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased **Oct. 8 1867**  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **Oct. 22**, 19**43**, to **Oct. 25**, 19**43**  
that I last saw her alive on **Oct. 24**, 19**43**  
and that death occurred on the date and hour stated above.

8. AGE: Years **76** Months **0** Days **17**  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Immediate cause of death **edema throat**  
**Streptococcus infection**  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Duration  
**1 day**  
**3 days**

9. Birthplace **Scotland**  
(City, town, or county) (State or foreign country)

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

10. Usual occupation **Housewife**  
11. Industry or business \_\_\_\_\_  
12. Name **James Cowden**  
13. Birthplace **Ireland**  
14. Maiden name **Isabelle O'Reilly**  
15. Birthplace **Ireland**

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

16. (a) Informant **Isabelle Donovan**  
(b) Address **4986 Rosalie Ave.**  
17. (a) **Burial** (b) Date thereof **10-28-43**  
(c) Place: burial or cremation **Calvary**  
18. (a) Signature of funeral director **Stroot-Carroll**  
(b) Address **4600 Natural Bridge**  
19. (a) **OCT 26 1943** (b) **J. P. Bresler**  
(Date received local registrar) (Registrar's signature)

23. Signature **Arthur S. ...** (M. D. or other) **10/20/43**  
Address **202 University** Date signed **10/26/43**

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

MOTHER FATHER

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**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 Sheldon Collier

Licensed Embalmer No. 3382

P. O. Address.....

**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, fact should be so stated above.**