7. S. No. 2
00M—2-43
ex. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 8 1944

Registration District No. 8

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 26179

Registrar's No. 7489

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
2626 S. Kingshighway Blvd.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 5 Yrs.

2. USUAL RESIDENCE OF DECEASED: 000

(a) State Mo (b) County 12

(c) City or town St. Louis 916
(If outside city or town limits, write "RURAL")

(d) Street No. 2626 S. Kingshighway
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME James J Donnelly

3. (b) If veteran, name war None

3. (c) Social Security No. None

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Annie

6. (c) Age of husband or wife if alive Decd years

7. Birth date of deceased Aug 4th. 1864
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
80	0	24	hr. min.

9. Birthplace St. Louis (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation Watchman

11. Industry or business City

FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Ireland (State or foreign country) 4

MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Ireland (State or foreign country) 4

16. (a) Informant Mrs Ann Steiner
(b) Address 4262 Humphrey St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/30/44 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemt

18. (a) Signature of funeral director Harrigan & Sheahan Und Co
(b) Address 4415 Washington Blvd.

19. (a) AUG 29 1944 (Date received local registrar) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 28th. year 1944 hour 4:30 AM minute M.

21. I hereby certify that I attended the deceased from 1934, 19, to Aug. 28, 1944, 19; that I last saw him alive on Aug. 27, 1944, 19; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage, August 24, 1944. (Duration)

Due to General arterio-sclerosis. (1934)

Due to Ch. Interstitial Nephritis

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.

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

23. Signature [illegible] M. D. (M. D. or other)
Address 320 Metropolitan Bldg. Date signed 8/28/44

(Licensed Embalmer's Statement on Reverse Side)

Dr O C Rainer
Metropolitan Bldg

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 Albert G Kapp

Licensed Embalmer No. 2971

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.