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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11157

FILED MAY 3 1945

Registration District No. 3948

Primary Registration District No. 1003

Registrar's No. 113586

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: Desloge Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 weeks-4 das (Specify whether
In this community 30 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 3315 rear N. 11th St
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Henry Donne

3. (b) If veteran, name war no

3. (c) Social Security No. no

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Mary Donne

6. (c) Age of husband or wife if alive 65 yrs years

7. Birth date of deceased Jan. 4, 1871 (Month) (Day) (Year)

8. AGE: Years 74 Months 73 Days 17 If less than one day hr. min.

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

10. Usual occupation nil

11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown (City, town, or county) uninown (State or foreign country)

MOTHER
14. Maiden name unknwon
15. Birthplace unknown (City, town, or county) unknown (State or foreign country)

16. (a) Informant Mrs. Dolores Molkenbur
(b) Address 2161 Salisbury St

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-24-'45 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director [signature]
(b) Address 2228 St. Louis Ave

19. (a) APR 23 1945 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4-21-45 day
year hour 5:30 a.m. minute M.

21. I hereby certify that I attended the deceased from 3-28-45, 19, to 4-21-45, 19;
that I last saw him alive on 4-21-45, 19;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage & shock

Due to Bleeding duodenal ulcer

Due to

Other conditions Urinary retention
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy Bleeding duodenal ulcer

Duration: Uncertain

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? (e) Means of injury

23. Signature W. J. Lage (M. D. or other) M.D.
Address Firmin Desloge Hosp. Date signed 4/21/45

(Licensed Embalmer's Statement on Reverse Side) Dr. W.J. Lage

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. Maxie R. Cashion

Licensed Embalmer No. 3949

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, fact should be so stated above.