

S. No. 2
-12-45
5-17-39
PI X47070

FILED MAY 9 1947
318

Registration District No. _____ Primary Registration District No. **1003**

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: **City Sanitarium**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **8 yrs. 9 mos. 2 ds.**
In this community **17 yrs.**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **000**
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL") **1317**
(d) Street No. **5400 Arsenal St.**
(If rural, give location) **9**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **FREDONIA DONAHUE**
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex **Female** 5. Color or race **col**
6. (a) Single, widowed, married, divorced **Mar**
6. (b) Name of husband or wife **S.K. Donahue** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **1869**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **April** day **14**
year **1947** hour **10.10** minute **P** M.
21. I hereby certify that I attended the deceased from **Feb. 15**, 19**46**, to **April 14**, 19**47**;
that I last saw h**er** alive on **April 14**, 19**47**;
and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day
abt. 78 ? ? hr. min.

Immediate cause of death **Arteriosclerotic Heart Disease**
2/15/46x
Due to **Senility.**

9. Birthplace **not given** **Arkansas**
(City, town, or county) (State or foreign country)

Other conditions **9/3**
(Include pregnancy within 3 months of death)

10. Usual occupation **Housework**
11. Industry or business _____
12. Name **not known?** 9
13. Birthplace **not known** 9
(City, town, or county) (State or foreign country)
14. Maiden name **not known** 7
15. Birthplace **not known** 7
(City, town, or county) (State or foreign country)

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

16. (a) Informant **Sanitarium Records**
(b) Address **5400 Arsenal St.**

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? _____

17. (a) **Anatomical Board** (b) Date thereof **MAY 2 1947**
(Burial, cremation, or removal) (Day) (Year)
(c) Place: burial or cremation **Anatomical Board**
18. (a) Signature of funeral director **W. Richter**
(b) Address **3500 Rutger**
19. (a) **J. F. Brebeck** (b) **J. F. Brebeck**
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place)
23. Signature **Jack R. Eidelman** (M. D. or other) **0**
Address **5400 Arsenal St.** Date signed _____

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

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.....

Licensed Embalmer No.....

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.