FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 31322

FILED OCT 9 1948

Registration District No. 318 — Primary Registration District No. 1005 — Registrar's No. 8431

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: ST LUKES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 DAYS (Specify whether years, months or days)
In this community 5 YRS

2. USUAL RESIDENCE OF DECEASED:
(a) State MO. (b) County ST LOUIS
(c) City or town WEBSTER GROVES
(If outside city or town limits, write "RURAL")
(d) Street No. 24 ALGONQUIN LANE (If rural, give location)
(e) Citizen of foreign country? N.R. (Yes or No)
If yes, name country —

3. (a) PRINT FULL NAME ANN LEE O'DONNELL
3. (b) If veteran, name war — 3. (c) Social Security No. —

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced WIDOW
6. (b) Name of husband or wife WM L. O'DONNELL 6. (c) Age of husband or wife if alive ... years
7. Birth date of deceased MARCH 21 1871 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
77	6	6	— hr. — min.

9. Birthplace FRANKFORT (City, town, or county) KENTUCKY (State or foreign country)
10. Usual occupation AT HOME
11. Industry or business —
MOTHER FATHER
12. Name JERRY LEE
13. Birthplace KENTUCKY (City, town, or county) (State or foreign country)
14. Maiden name JANE ALLEN
15. Birthplace ENGLAND (City, town, or county) (State or foreign country)
16. (a) Informant Dr. Jno. Patterson Jr.
(b) Address 24 ALGONQUIN LANE
17. (a) REMOVAL (Burial, cremation, or removal) (b) Date thereof 9-29-48 (Month) (Day) (Year)
(c) Place: burial or cremation FRANKFORT KY
18. (a) Signature of funeral director Parker Funeral Co.
(b) Address WEBSTER GROVES
19. (a) SEP 28 1948 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 27 day Sept X year 1948 hour noon minute ... M.
21. I hereby certify that I attended the deceased from 2/23/48, 19..., to 9/27/48, 19...; that I last saw her alive on 9/26/48, 19...; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
(1) Cerebral Thrombosis	36 hrs
Fracture left hip	
Due to: Arteriosclerosis	several yrs
Due to: (Cerebral)	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations: Trochanteric Fracture (hip was nailed)
Of autopsy: no

PHYSICIAN: Underline cause of 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 A Victor Pelle (M. D. or other)
Address Webster Groves Date signed 9/27/48

Jefferson City Printing Co. (Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 Leslie Welch

Licensed Embalmer No. 4395

P. O. Address Webster Groves 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.