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FILED OCT 23 1948
Registration District No. 18

Primary Registration District No. 1003

State File No. _____
Registrar's No. 8875

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

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:
Homer G. Phillips Hospital.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3 days
(Specify whether
In this community 20 years
years, months or days)

3. (a) PRINT FULL NAME James Donelson

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Col. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie Donelson 6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased About 1906
(Month) (Day) (Year)

8. AGE: Years 42 Months - Days - If less than one day hr. _____ min. _____

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

10. Usual occupation Janitor

11. Industry or business _____

12. Name A. Donelson

13. Birthplace Okolona, Miss.
(City, town, or county) (State or foreign country)

14. Maiden name D. Smith

15. Birthplace Okolona, Miss.
(City, town, or county) (State or foreign country)

16. (a) Informant Minnie Donelson

(b) Address 402 So. Montrose Ave.

17. (a) Burial (b) Date thereof Oct 16, 1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oakdale, Cemetery

18. (a) Signature of funeral director Wright's Funeral Home.

(b) Address 3100 Easton Ave.

19. (a) OCT 13 1948 (b) [Signature]
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County [unclear]
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 402 So. Montrose Ave.
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day Oct
year 1948 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Cerebral Angiopathy
Due to _____
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____
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? 3

(Specify type of place) _____ (c) Means of injury _____
While at work _____

23. Signature [Signature] (M. D. or other) _____
Address _____ Date signed [unclear]

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 Arthur L. Hilliard

Licensed Embalmer No. 4221

P. O. Address. 4049 St Ferdinand

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.