

300
0-47
7-39
3906

FEDERAL SECURITY AGENCY
National Office of Vital Statistics
FILED NOV 19 1948

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

38495

State File No. _____

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **9680**

1. PLACE OF DEATH:

(a) County _____

(b) City or town **St. Louis, Mo.**

(c) Name of hospital or institution: **Infirmiry Hospital**
(If outside city or town limits, write "RURAL" and name of township)

(d) Length of stay: In hospital or institution **12/20/44 to 11/4/48** to
(Specify whether years, months or days)

In this community _____

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**

(c) City or town **City Infirmiry**
(If outside city or town limits, write "RURAL")

(d) Street No. **13** (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME **LETHA O'DONALD**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month **NOV.** day **4**
year **1948** hour **9** minute **40** P.M.

21. I hereby certify that I attended the deceased from **July 7, 1948** 19 **NOV. 4** 19 **48**
that I last saw **her** alive on **NOV. 4** 19 **48**
and that death occurred on the date and hour stated above.

4. Sex **Female** 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Widow 2**

6. (b) Name of husband or wife **Tom O'Donald** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **September 1st 1890**
(Month) (Day) (Year)

Immediate cause of death **Hypertensive renal disease**

Due to _____

Due to _____

Other conditions **Ventral Hernia**
(include pregnancy within 3 months of death)

8. **AGE:** Years **58** Months **2** Days **3** If less than one day hr. _____ min. _____

9. Birthplace **Starksville, Mississippi**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

PHYSICIAN

Major findings:
Of operations _____

Of autopsy **refused**

Underline the cause to which death should be charged statistically.

MOTHER, FATHER

12. Name **Wash Johnson**

13. Birthplace **Starksville, Mississippi**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Moody**

15. Birthplace **Starksville, Mississippi**
(City, town, or county) (State or foreign country)

16. (a) Informant **Pearl Johnson**

(b) Address **3956 Aldine Avenue**

17. (a) **Burial** (b) Date thereof **11/10/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park Cem.**

18. (a) Signature of funeral director **Chas. J. Gates**

(b) Address **4107 Finney Avenue**

19. (a) **NOV 8** (b) **J. B. Casater**
(Date received by Registrar) (Registrar's signature)

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? _____

While at work? _____ (Specify type of place)

(e) Means of injury _____

23. Signature **Cletus S. Krag** (M. D. or other) **11/15/48**
Address **5600 Arsenal St. St. Louis**

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.....

.....**John K. Cunningham**....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

John K. Cunningham

Licensed Embalmer No.....**4476**.....

P. O. Address.....**4107 Finney Avenue**.....

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.