

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **32887**  
Registrar's No. **8551**

**1952** OCT 1

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo.</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>Mo. Baptist Hospital</b>		d. STREET ADDRESS (If rural, give location) <b>5832 Cabanne Ave.</b>	

3. NAME OF DECEASED (Type or Print) a. (First) <b>Ann</b> b. (Middle) c. (Last) <b>Donegan</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>Sept. 10, 1952</b>		
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <b>June 18, 1882</b>		9. AGE (In years, less birthday) <b>70</b> If under 1 year: Months <b>2</b> Days <b>22</b> If under 24 hours: Hours <b>0</b> Mins.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					

13a. FATHER'S NAME <b>John Friel</b>		13b. MOTHER'S MAIDEN NAME <b>Jennie McSorley</b>		14. NAME OF HUSBAND OR WIFE <b>John T. Donegan</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. Harry Lunt, 5832 Cabanne Ave.</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <b>1 Mo.</b>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Chronic Debility, loss of Vital Function, Autotonia and Gas Gangren of Abdominal Wall</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Perianal Abscess</b> DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION <b>6/21 Aug 52</b>		19b. MAJOR FINDINGS OF OPERATION <b>Fistula from rectum to buttock &amp; Rt. Abdominal</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <b>574x</b>	

22. I hereby certify that I attended the deceased from **3 July, 1952, to 10 Sep, 1952**, that I last saw the deceased alive on **9 Sep, 1952**, and that death occurred at **3:15 Pm.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>J. Ernest Jones M.D.</b>		23b. ADDRESS <b>634 N. Grand Blvd.</b>		23c. DATE SIGNED <b>11 Sep 52</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>Sept. 13, 1952</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>	
24d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>					

DATE REC'D BY LOCAL REG. <b>SEP 12 1952</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith M.D.</b>		FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Arthur J. Donnelly 500 Lindell Blvd.</b>	
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(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 me

Student Embalmer No. ....

working under my personal supervision.

Student .....  
Student Embalmer

Signed *Wm S. DeWitt*

Licensed Embalmer No. 4699

P. O. Address St. Charles, 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.