

health, Welfare Public Service
 300
 1-56
 Social, Colander, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.
 USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
 MEDICAL CERTIFICATION 7/22/57
 done by [signature]

FILED JUN 25 1957

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

57-0-23312
 STATE FILE NUMBER

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 100

1. PLACE OF DEATH a. COUNTY <u>Vernon</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Laclede</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Washington Township</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		c. CITY OR TOWN <u>Lebanon</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>State Hospital 3</u>			Length of stay in lb <u>26 days</u>	d. STREET ADDRESS (If outside, give location) <u>Rural Route</u>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>LEWIS - EDWARD - DONOVAN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>1884 April 19, 1883</u>	9. AGE (In years last birthday) <u>73</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>23</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and state or country) <u>St Louis Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Donovan</u>				14. MOTHER'S MAIDEN NAME <u>Bessie Roarce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records State Hospital 3, Nevada, Mo</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) <u>arteriosclerotic Heart Disease</u>		DUE TO (c) <u>4200</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome - arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>10</u> Month <u>May</u> Day <u>17</u> Year <u>1957</u> A. M. P. M.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION		STATE	
21. I attended the deceased from <u>May 17, 1957</u> , to <u>June 11, 1957</u> and last saw <u>her</u> alive on <u>June 11, 1957</u> Death occurred at <u>10:30 A</u> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Paul L. Barone, MD</u>				22b. ADDRESS <u>State Hospital 3 Nevada Mo</u>		22c. DATE SIGNED <u>June 11/57</u>	
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE <u>6-12-57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holles Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Laclede Co., Mo.</u>		
24. FUNERAL DIRECTOR <u>Palmer Funeral Home</u>		ADDRESS <u>Lebanon, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>6-18-1957</u>		26. REGISTRAR'S SIGNATURE <u>Anna J. Flory</u>	

(Licensed Embalmer's Statement on Reverse Side)

JUN 25 1951

AUG 7 1951

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was

by me, or by Student Embalmer No.....

working under my personal supervision.

Student.....
Signature of Student Embalmer

Signed..... *Percy F. Milster*

Licensed Embalmer No. 48

P. O. Address Nevada

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).

if embalmed by a-STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.