

FILED AUG 5 1957

 THE DIVISION OF HEALTH OF MISSOURI  
 STANDARD CERTIFICATE OF DEATH

23587

STATE FILE NUMBER

 Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 836

1. PLACE OF DEATH a. COUNTY <b>Buchanan</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Buchanan</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Joseph</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Joseph</b> 01170 Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>418 So. 11th</b>		Length of stay in lb <b>19 Yrs</b>	d. STREET ADDRESS <b>418 So. 11th</b> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Bridget</b> Middle <b>Irene</b> Last <b>Donovan</b>			4. DATE OF DEATH <b>July 25, 1957</b> Month Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 2, 1881</b>
9. AGE (In years last birthday) <b>76</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Cameron, Mo.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Patrick Kil Martin</b>	
14. MOTHER'S MAIDEN NAME <b>Bridget Frahal</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 <b>Mrs Bart O'Connor</b> Address City <b>418 So. 11th</b>	
18. CAUSE OF DEATH [Enter only one cause per line in (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure, Acute</b> DUE TO (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (n) <b>4200</b>			INTERVAL BETWEEN ONSET AND DEATH <b>12 hr</b> <b>Yrs.</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>2</b>		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 Month, Day, Year 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		COUNTY STATE	
21. I attended the deceased from <b>10-6-57</b> to <b>7-25-57</b> and last saw her alive on <b>7-25-57</b> Death occurred at <b>1:45 p.m.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Robert A. Kilde, M.D.</b>		22b. ADDRESS <b>St. Joseph, Mo</b>	
22c. DATE SIGNED <b>7-26-57</b>		23a. NAME OF CEMETERY OR CREMATORY <b>St. Joseph's Cemetery</b>	
23b. LOCATION (City, town, or county) <b>Easton, Mo.</b>		(State)	
23c. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23d. DATE <b>July 29, 1957</b>	
24. FUNERAL DIRECTOR <b>Herman W. Lindenbinder</b>		ADDRESS <b>St. Joseph, Mo</b>	
25. DATE RECD. BY LOCAL REG. <b>Aug. 2, 1957</b>		26. REGISTRAR'S SIGNATURE <b>Mrs. Roberts Fulton</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Coroner cannot certify to a death due to natural causes.

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(Licensed Embalmer's Statement on Reverse Side)

*Dr. Kieber*

STATEMENT BY LICENSED EMBALMER

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

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

working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Robert H. Gypsh*

Licensed Embalmer No. 330

P. O. Address St. Josep

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.