

AMENDED
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Length of stay in 1b	c. CITY OR TOWN Richmond Heights
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 11 Whitehall Ct.
3. NAME OF DECEASED (Type or print) First MARTHA Middle KELLY Last DONAHIE		4. DATE OF DEATH Month JANUARY Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10-21-1904
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE (last birthday) 56
11. BIRTHPLACE (City and state or country) Belmont Ohio		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME George Kelly		13b. MOTHER'S MAIDEN NAME Gussie Wright	
14. NAME OF HUSBAND OR WIFE Howard J. Donahie			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none		16. SOCIAL SECURITY NO. none	17. INFORMANT Mr. Howard Donahie
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT BREAST WITH WIDESPREAD METASTASES		INTERVAL BETWEEN ONSET AND DEATH 5 YEARS	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) 170x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 a.m. p.m.	Month, Day, Year		
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 JUNE 1, 1950 to JAN. 20, 1961 and last saw her him alive on JAN. 20, 1961			
Death occurred at 12:40 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <i>C. D. Donahie, M.D.</i>		22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 1/20/61
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Jan. 23, 1961	23c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery	23d. LOCATION (City, town, or county) Belmont Ohio
24. FUNERAL DIRECTOR ADDRESS C.R. Lupton and Sons 7233 Delmar		25. DATE RECD. BY LOCAL REG. JAN 21 1961	26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i>

STATE OF MISSOURI
DEPARTMENT OF HEALTH

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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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Arnold W. Schoene

Licensed Embalmer No. 3864
P. O. Address St. Louis, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.