

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-049377  
STATE FILE NUMBER

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 12490

DO NOT WRITE ON THIS STUB

VS 300	AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)
Rev. 4/59	
1	
2 <u>216</u>	
3	
4 <u>0</u>	
5 <u>0</u>	
6	
7 <u>0</u>	
8 <u>2</u>	
9	
10	
11	
12 <u>90-2</u>	
13	
<u>90</u>	

**FILED DEC 27 1963**

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY		c. CITY OR TOWN <u>St. Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>2917 Pennsylvania</u>				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>2917 Pennsylvania</u>				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael J. Donovan</u>						4. DATE OF DEATH Month <u>Dec.</u> Day <u>16</u> Year <u>1963</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>9/29/44</u>		9. AGE (last birthday) <u>19</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>St. Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>			
13a. FATHER'S NAME <u>Rex Donovan</u>				13b. MOTHER'S MAIDEN NAME <u>Adra Woodall</u>				14. NAME OF HUSBAND OR WIFE			
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.		17. INFORMANT Address <u>Rex Donovan 2917 Pennsylvania</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>Uremia</u> <u>Myocardial failure.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>592X</u> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
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 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 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 <u>1957</u> to <u>12-16-63</u> and last saw <sup>her</sup> him alive on <u>12-16-63</u> Death occurred at <u>6:30 p</u> on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Dr. Edellee J. Lance D.O.</u>						22b. ADDRESS <u>3615 So. Grand</u>			22c. DATE SIGNED <u>12-17-63</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>Dec. 17, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Summersville Cem.</u>		23d. LOCATION (City, town, or county) <u>Summersville</u>		STATE <u>Mo.</u>			
24. FUNERAL DIRECTOR <u>Thomas Kuter</u>				ADDRESS <u>2906 Graves</u>		25. DATE RECD. BY LOCAL REG. <u>DEC 17 1963</u>		26. REGISTRAR'S SIGNATURE <u>Loan Smith. M.D.</u>			

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS (INSTEAD OF)

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

90-2

90

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

USE BLACK INK OR TYPEWRITER RIBBON

Original: 19. See to the 1963 final DOCUMENT

STATE OF MISSOURI

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 *Carol Hays*

Licensed Embalmer No. 4861

P. O. Address St Louis, Mo 65119

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.

*Dr. E. H. Kanner  
3615 S. Grand*

*MO 4-5440*