

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

**1. PLACE OF DEATH**

County Jackson  
Township Jackson  
City Jackson

Registration District No. 399  
Primary Registration District No. 1100

File No. 37856  
Registered No. 1124  
St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME**

(a) Residence, No. 7806 E 11th St., Ward \_\_\_\_\_  
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>September 18-1898</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)		
7. AGE	YEARS <u>53</u>	MONTHS <u>7</u>
	DAYS <u>29</u>	IF LESS than 1 day, hrs. min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. <u>at home</u>	
	9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.	
	10. Date deceased last worked at this occupation (month and year)	
	11. Total time (years) spent in this occupation	
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Missouri</u>		
FATHER	13. NAME <u>Frank McDonnell</u>	
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>	
MOTHER	15. MAIDEN NAME <u>Katey Donnelly</u>	
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ireland</u>	
17. INFORMANT (ADDRESS) <u>E. J. Noonan</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Calvary</u> DATE <u>11/27/31</u>		
19. UNDERTAKER (ADDRESS) <u>F. J. McDonnell</u> <u>325 Broadway</u>		
20. FILED <u>11/26/31</u> <u>M. M. Crowe</u> <u>Asst. Registrar.</u>		

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) November 15, 1931

22. I HEREBY CERTIFY, That I attended deceased from 11-22, 1931, to 11-25, 1931. I last saw her alive on 11-24, 1931. Death is said to have occurred on the date stated above, at 5 am. The principal cause of death and related causes of importance were as follows:

<u>Carcinoma of ascending colon</u>	Date of onset
<u>Cholelithiasis</u>	
<u>Chronic Endocarditis</u>	

Other contributory causes of importance:  
Cholelithiasis

Name of operation Resection of Colon Date of 11-23  
What test confirmed diagnosis? Pathology Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
If so, specify \_\_\_\_\_  
(Signed) A. J. Welch, M. D.  
(Address) 235 Rusk

