

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.

AY 25 1934

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

Do not use this space.

9644

1. PLACE OF DEATH  
 County Macon Registration District No. 533  
 Township Macon Primary Registration District No. 3027  
 City H. M. Donaghy (No. \_\_\_\_\_) St. \_\_\_\_\_ Ward \_\_\_\_\_  
 2. FULL NAME H. M. Donaghy  
 (a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_  
 (Usual place of abode) (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male  
 4. COLOR OR RACE W  
 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR WIFE OF) Lucy V. Donaghy  
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 24 1861  
 7. AGE YEARS 72 MONTHS 7 Days 4 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Retired Merchant  
 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) Jackson Co. Mo.  
 13. NAME James Donaghy  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 15. MAIDEN NAME Kate Campbell  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.  
 17. INFORMANT (ADDRESS) William Donaghy Macon, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Waldwood Cem. DATE 3/30/34  
 19. UNDERTAKER (ADDRESS) Stephens & Gooding Macon Mo.  
 20. FILED April 10 1934 U. Kane Cross Registrar

**(3) MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 3-28 1934  
 22. HEREBY CERTIFY, That I attended deceased from Jan 21 1931 to 3-28 1934  
 I last saw him alive on 3-28 1934 Death is said to have occurred on the date stated above, at 8:15 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Cardio-vascular  
Renal Disease  
Prostatic hypertrophy  
Blindness (optic nerve atrophy)  
 Date of onset 8-16/1931  
 Other contributory causes of importance:  
1920  
1932  
 23. Name of operation Prostatectomy Date of \_\_\_\_\_  
 What test confirmed diagnosis? Clinical 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) J. J. Lonoway, M. D.  
 (Address) Macon Mo.

