

DEC 8 JUL 18 1939

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

22631
Do not use this space.

1. PLACE OF DEATH

(a) County Macomb Registration District No. 534
(b) Township Linger Primary Registration District No. 5517
(c) City..... (d) Street No.....
(If death occurred in Hospital or Institution, write its name instead of street and number) St.
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 6

2. PRINT FULL NAME

354 Mollie O'Donnell
(a) Residence, No..... St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Ed O'Donnell

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec 23-1868

7. AGE YEARS / MONTHS DAYS If LESS than 1 day, hrs. or min.
71 / 4 / 17

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Housekeeper
9. Industry or business in which work was done, as 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) Texas

FATHER 13. NAME Simon Welsh

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

MOTHER 15. MAIDEN NAME Sarah

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ireland

17. INFORMANT (ADDRESS) Pat Welsh
Margeline MC

18. BURIAL, CREMATION, OR REMOVAL PLACE Linger Cemetery DATE June 17, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) H. J. Hilliard
New Orleans, La.

20. FILED July 8, 1939 Ed West Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 15, 1939

22. I HEREBY CERTIFY That I attended deceased from June 15, 1939 to June 15, 1939
I last saw h..... alive on....., 19..... Death is said to have occurred on the date stated above, at 3 P. m.
The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset 1938
93C
Other contributory causes of importance:
old age + high Blood Pressure 1938

Name of operation..... Date of.....
What test confirmed diagnosis? Observed 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 Lowest Coronary M. D.
(Signed) Ed West (Address) New Orleans, La.
841

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.

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,

H. F. Gilleland

or by

Registered Apprentice No. _____, working under my personal supervision.

Signed

H. F. Gilleland

Licensed Embalmer No.

4019

P. O. Address

New Cambria 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 this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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CERTIFICATE OF DEATH

22631
Do not use this space.

1. PLACE OF DEATH

(a) County Macon Registration District No. 534
(b) Township Lingo Primary Registration District No. 3717 Registered No. 6
(c) City..... (d) Street No..... St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mollie O'Donnell

(a) Residence, No. St. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 6-15-1939

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

22. I HEREBY CERTIFY, That I attended deceased from

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 12-23-1868

I last saw h..... alive....., 19..... Death is said

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
70 5 22

to....., 19.....

to have occurred on the date stated above, at.....m.

The principal cause of death and related causes of importance were as follows:

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

Date of onset

Other contributory causes of importance:

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Name of operation..... Date of.....

13. NAME

What test confirmed diagnosis?..... Was there an autopsy?.....

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide?..... Date of injury....., 19.....

15. MAIDEN NAME

Where did injury occur?..... (Specify city or town, county, and State)

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Specify whether injury occurred in industry, in home, or in public place.

17. INFORMANT (ADDRESS)

Manner of injury.....

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

Nature of injury.....

19. FUNERAL DIRECTOR (ADDRESS)

24. Was disease or injury in any way related to occupation of deceased?.....

20. FILED July 8, 1939 O'Donnell Local Registrar.

If so, specify C. O. West M.D.

(Address) New Cambria Mo.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTARY

