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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **42840**

FILED JAN 14 1944  
Registration District No. **5691**

Primary Registration District No. **5691**

Registrar's No. **21**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County **Linn**

(b) City or town **Jefferson Rural**  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **1**  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **55 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **ALEXANDER McDONNELL**

3. (b) If veteran, name war: **No.**

3. (c) Social Security No. **No.**

4. Sex **Male** 5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Wife**

6. (c) Age of husband or wife if alive **52** years

7. Birth date of deceased **July 28 - 1876**  
(Month) (Day) (Year)

8. AGE: Years **67** Months **4** Days **6** If less than one day hr. min.

9. Birthplace **Lelancee Mo**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farming**

11. Industry or business

12. Name **Alexander McDonnell**

13. Birthplace **Tiperary Ireland**  
(City, town, or county) (State or foreign country)

14. Maiden name **Ellen Kempsey**

15. Birthplace **Tiperary Ireland**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Ellen McDonnell**

(b) Address **Laclede, Mo.**

17. (a) **Burial** (b) Date thereof **12-7-1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **St. Michel - Brookfield Mo.**

18. (a) Signature of funeral director **Messinger**

(b) Address **Laclede, Linn Co., Mo.**

19. (a) **Dec. 8, 1943** (b) **Mrs. Viria Rowland**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Linn**

(c) City or town **Rural Jefferson**  
(If outside city or town limits, write "RURAL")

(d) Street No. **1** (If rural, give location)

(e) Citizen of foreign country? **No.** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec.** day **4**  
year **1943** hour **1** minute **40** p. M.

21. I hereby certify that I attended the deceased from **Nov 1, 1943** to **Dec 4, 1943**; that I last saw him alive on **Dec 4, 1943** and that death occurred on the date and hour stated above.

Immediate cause of death **Hypertrophy of prostate (Bladder)** Duration **4 1/2 yr**

Due to **Membrane poisoning** **6 wks**

Due to **Coronary sclerosis** **4 yr**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **Roy Hala** (M.D. or other) **MSD**  
**Brookfield Mo.** Date signed **12-7-43**

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 Me

W. S. Thamm, Registered Apprentice No. 2876  
working under my personal supervision.

Signed W. S. Thamm

Licensed Embalmer No. 2876

P. O. Address Salida, 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. *Jan.*

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County *Linn*
- (b) City or town *Rural*
- (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether

In this community *55 yr*  
years, months or days)

3. (a) PRINT FULL NAME

*Alexander Mc Donnell*

- 3. (b) If veteran, name war \_\_\_\_\_

- 3. (c) Social Security No. \_\_\_\_\_

- 4. Sex *m* 5. Color or race *w*

- 6. (a) Single, widowed, married, divorced *m*

- 6. (b) Name of husband or wife \_\_\_\_\_

- 6. (c) Age of husband or wife if \_\_\_\_\_

- 7. Birth date of deceased *July 18 1875*  
(Month) (Day) (Year)

- 8. AGE: Years *67* Months *4* Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

- 9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

- 10. Usual occupation \_\_\_\_\_

- 11. Industry or business \_\_\_\_\_

MOTHER FATHER

- 12. Name \_\_\_\_\_

- 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

- 14. Maiden name \_\_\_\_\_

- 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

- 16. (a) Informant \_\_\_\_\_

- (b) Address \_\_\_\_\_

- 17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

- (c) Place: burial or cremation \_\_\_\_\_

- 18. (a) Signature of funeral director \_\_\_\_\_

- (b) Address \_\_\_\_\_

- 19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State \_\_\_\_\_ (b) County \_\_\_\_\_
- (c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")
- (d) Street No. \_\_\_\_\_ (If rural, give location)
- (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

- 20. DATE OF DEATH: Month *December* Day *14* Year *1943* Hour \_\_\_\_\_ minute \_\_\_\_\_ M.

- 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

*Hypertrophy of Prostate Gland*

Due to *Uremic Poisoning*

Due to *Coronary Sclerosis*  
*Chronic Parenchymatous Nephritis*

Other conditions: \_\_\_\_\_ (Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

- 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify) \_\_\_\_\_

- (b) Date of occurrence \_\_\_\_\_

- (c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

- (d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

- 23. Signature *Boyd Haley* (M. D. or other) *M.D.*

Address *Brookfield Mo* Date signed *1-12-44*

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

SUPPLEMENTARY

5-42840