

FILED AUG 14 1944

Registration District No. _____

Primary Registration District No. **4169**

Registrar's No. **217**

1. PLACE OF DEATH:

(a) County **DeKalb**
(b) City or town **Dabon**
(If outside city or town limits, write "RURAL" and name of township)
(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 **Life** years, months or days

3. (a) PRINT FULL NAME **JAMES EDWIN McDONOUGH**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **white** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **India M. McDonough** 6. (c) Age of husband or wife if alive **64** years
7. Birth date of deceased **Nov 11 1878**
(Month) (Day) (Year)

8. AGE: Years **65** Months **7** Days **27** If less than one day _____ hr. _____ min.

9. Birthplace **DeKalb Co. Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Drug est.**

11. Industry or business _____

MOTHER FATHER { 12. Name **John C. M. McDonough**
13. Birthplace **NY**
(City, town, or county) (State or foreign country)
14. Maiden name **Catherine M. McDonough**
15. Birthplace **NY**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs J. E. M. McDonough**
(b) Address **Dabon Mo.**

17. (a) _____ (b) Date thereof **July 12 1944**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Evergreen Cemetery Dabon**

18. (a) Signature of funeral director **J. S. Gale**

(b) Address **St. Louis Mo.**

19. (a) **July 31 1944** (b) **John C. McDonough**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **DeKalb**
(c) City or town **Dabon Mo.**
(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 **July** day **9th** -
year **1944** hour **6** minute **45 P.** M.

21. I hereby certify that I attended the deceased from **July 9** 1944 to **July 9** 1944
that I last saw him alive on **July 9** 1944
and that death occurred on the date and hour stated above.
Immediate cause of death **Apoplexy** Duration _____

Due to _____

Due to _____

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 **J. S. Gale** (M. D. or other)

Address **Dabon Mo.** Date signed **July 9 1944**

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

3200

1378

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

Signed J. G. Lyons
Licensed Embalmer No. 952
P. O. Address Stewartville 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.