

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42575

Registrar's No. 177

Registration District No. 324

Primary Registration District No. 6092

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

1. PLACE OF DEATH:

(a) County Saline

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

(c) Name of hospital or institution: Marshall Home
2 1/2 mi N. Shackelford mo
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether

In this community 77 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97

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

(d) Street No. 2 1/2 mi N. Shackelford mo
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME JOHN M. DONOUGH

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 Widowed

6. (b) Name of husband or wife Catherine Flynn Mc Donough 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Feb - 1 - 1857
(Month) (Day) (Year)

8. AGE: Years 88 Months 10 Days 21 If less than one day _____ hr. _____ min.

9. Birthplace Schuyler Co Ill
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Thomas Mc Donough

13. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Boyle

15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs John Mc Combs

(b) Address Marshall mo R 3

17. (a) Burial (b) Date thereof 12-21-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Marys Cem. Saline Co mo

18. (a) Signature of funeral director Harry Hershberger

(b) Address Marshall mo

19. (a) 12/22/45 (b) Mo T. O. Weathrock
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22
year 1945 hour 4 minute 00 A. M.

21. I hereby certify that I attended the deceased from Jan 1, 1945
to Dec 21, 1945 to _____ 19____
that I last saw h. m. alive on Dec 21, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Bronchial Pneumonia 3 days

Due to Senility

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration

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 C. J. Harren (M. D. or other) DO
Address Marshall mo Date signed 12/22/45

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

1-11-46

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 Harry Hershberger

Licensed Embalmer No. 4357

P. O. Address Marshall 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.