

MAY 15 1940

Registration District No. 16

Primary Registration District No. 5682

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Livingston *Yorkshire Pa.*

(b) City or town Rural

(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 50 yrs. (years, months or days)

3. (a) PRINT FULL NAME Jabin Donovan *B.15*

8. (b) If veteran, name war _____ (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 Maggie B. Donovan

6. (c) Age of husband or wife if alive 75 years

7. Birth date of deceased Sept. 28 1863

(Month) (Day) (Year)

8. AGE: Years: 76 Months: 6 Days: 10

If less than one day: _____ hr. _____ min.

9. Birthplace Unknown

(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER

12. Name John W. Donovan

13. Birthplace Unknown

(City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown

(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Evelyn Galona

(b) Address Chula, Mo.

17. (a) Burial (b) Date thereof 4/9/40

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Edgewood Cem.

18. (a) Signature of funeral director Jamond Gordon

(b) Address Chilliothe, Mo.

19. (a) 4-11-1940 (b) [Signature]

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Rural

(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7

year 1940 hour 9:50 minute _____ A.M.

21. I hereby certify that I attended the deceased from MARCH 31st, 1940, to APRIL 7th, 1940

that I last saw him alive on APRIL 7th, 1940

and that death occurred on the date and hour stated above.

Immediate cause of death CEREBRAL HEMORRHAGE

Duration _____

Due to _____

Due to _____

Other conditions HYPOSTATIC PNEUMONIA 3 days

(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? 4/6/40

(Specify type of place) _____ (Means of injury) _____

23. Signature [Signature] (M. D. or other) _____

Address Chula Mo Date signed 4-8-40

WHILE PLAINLY USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—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.

1 X10511

RECEIVED
District Health Officer No. 114
District File Number 540-122
Date Filed MAY 9 1940

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.....

Donald F. Gordon....., Registered Apprentice No. 223
working under my personal supervision.

Signed James D. Gordon
Licensed Embalmer No. 1870
P. O. Address Lehillecothe, 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.