No. 2
1-10-39
17-391
XZ1

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31741

OCT 12 1940

Registration District No. 98

Primary Registration District No. 3011

Registrar's No. 147

1. PLACE OF DEATH:

(a) County: Clay

(b) City or town: Excelsior Springs, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Veterans Administration Facility
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution: 7 mos., 15 days (Specify whether years, months or days) 3

In this community: 7 mos. 15 days

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Jackson

(c) City or town: Kansas City
(If outside city or town limits write "RURAL")

(d) Street No.: 3804 Benton Blvd.
(If rural, give location)

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

3. (a) PRINT FULL NAME: John T. Donnellan

3. (b) If veteran, name war: Spanish American

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Deceased-Unknown

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

7. Birth date of deceased: Mar. 7, 1871 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
69	6	9	hr. min.

9. Birthplace: Laramie Wyo. (City, town, or county) (State or foreign country) 1

10. Usual occupation: Insurance Salesman 5

11. Industry or business: Insurance 1

FATHER
12. Name: John W. Donnellan 1
13. Birthplace: Ireland (City, town, or county) Ireland (State or foreign country)

MOTHER
14. Maiden name: Marian McNasser
15. Birthplace: ? (City, town, or county) Vermont (State or foreign country)

16. (a) Informant: Hospital Records

(b) Address:

17. (a) Kansas City, Mo. (b) Date thereof: 9-17-40 (Month) (Day) (Year)
(Burial, cremation, or removal) Removal

(c) Place: burial or cremation: Kansas City, Mo.

18. (a) Signature of funeral director: Claude Prichard

(b) Address: Excelsior Springs, Mo.

19. (a) 9-17-40 (Date received local registrar) (b) Mae Rea McCracken (Registrar's signature) 140

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept. day: 16th year: 1940 hour: 9:10 minute: P. M.

21. I hereby certify that I attended the deceased from Feb. 1, 1940, to Sept. 16, 1940; that I last saw him alive on Sept. 16, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Asthma, bronchial	
Emphysema, Pulmonary	
Due to: Bronchiectasis	
Other conditions: -- (Include pregnancy within 3 months of death)	
Major findings: Of operations: none	
Of autopsy: As shown above	

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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: W. A. German (M. D. or other) M. D.
W. A. GERMAN, Clinical Director

Address: Veterans Administration Facility, Excelsior Springs, Mo. 9-17-40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 10-2-40
Date Filed

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 Robert Ray, Registered Apprentice No. 226 working under my personal supervision.

Signed Claude Cochran

Licensed Embalmer No. 2751

P. O. Address Excelsior Spgs., Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply w the above constitutes grounds for revocation of license.)

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