

BUREAU OF THE CENSUS
FILED MAR 18 1946

STANDARD CERTIFICATE OF DEATH

State File No. _____

Registration District No. 237Primary Registration District No. 4497Registrar's No. 20

1. PLACE OF DEATH:

(a) County SHELBY
 (b) City or town CLARENCE
 (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 _____
 years, months or days

3. (a) PRINT FULL NAME WILLIAM F. DONNELL

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

4. Sex MALE 5. Color or race W
 6. (a) Single, widowed, married, divorced MARRIED
 6. (b) Name of husband or wife Nellie M. Donnell
 6. (c) Age of husband or wife if alive 87 years
 7. Birth date of deceased sep 21 - 1856
 (Month) (Day) (Year)

8. AGE: Years 89 Months # Days 29
 If less than one day _____ hr. _____ min.

9. Birthplace Ind. Indiana
(City, town, or county) (State or foreign country)10. Usual occupation RETIRED FARMER

11. Industry or business _____

MOTHER, FATHER { 12. Name Cyrus Donnell 9
 13. Birthplace not known 9
 (City, town, or county) (State or foreign country)
 14. Maiden name not known
 15. Birthplace Ind. 9
 (City, town, or county) (State or foreign country)

16. (a) Informant Glen Jonell(b) Address Clarence Mo17. (a) BURIAL (b) Date thereof 2-24-46
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation BELHEL Cem18. (a) Signature of funeral director William S. Barkler(b) Address Clarence Mo19. (a) Mar 5-46 (b) Keith Jayne
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Shelby 102
 (c) City or town Clarence 1
 (If outside city or town limits, write "RURAL") 0
 (d) Street No. _____ (If rural, give location) 0
 (e) Citizen of foreign country? NO (Yes or No) 0
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 20
year 1946 hour 9 minute 30 P.M.21. I hereby certify that I attended the deceased from Nov. 1945 to Feb. 20, 1946
that I last saw him alive on Feb. 20, 1946
and that death occurred on the date and hour stated above.

Immediate cause of death _____

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? _____

(Specify type of place) _____
 While at work? _____ Means of injury 0
 23. Signature Frank R. Roy (M. D. or _____)
 Address Clarence, Mo. Date signed 2-21-46

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

RECEIVED
District Health Officer No. 1
District File Number 3-46-436
Date Filed MAR 12 1946

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 Henry G. Bartles

Licensed Embalmer No. 3835

P. O. Address Shelburne Vt

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. April
Registrar's No. 20

Registration District No. 337

Primary Registration District No. 4497

1. PLACE OF DEATH:

(a) County Shelby
(b) City or town Clarence
(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 _____
years, months or days)

3. (a) PRINT FULL NAME William J. Oarell
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 alive _____ years

7. Birth date of deceased Sept 2
(Month) (Day) (Year)

8. AGE: Years 89 Months _____ Days _____
If less than one day hr. _____ min. _____

9. Birthplace _____
(City, town, or county) (State or foreign country) Ind

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (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 _____ Day _____
Year 1946 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Duration _____

Due to X Ray did not reveal cause of esophagus obstruction. Patient claimed he could not swallow. He could drink fluids
Due to _____
Other conditions _____
(Include pregnancy within 3 months of death)

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

Major findings:
Of operations _____

Of autopsy 116"

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 Frank N. Roy (M. D. or other) _____
Clarence, Mo. Address _____ Date signed 3-11-46

SUPPLEMENTARY

11921