

No. 4-13-3
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

NOV 2 6 1940

STANDARD CERTIFICATE OF DEATH

35777
State File No. _____

Registration District No. 333

Primary Registration District No. 3027

Registrar's No. 64

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

1. PLACE OF DEATH: Macon
 (a) County Macon
 (b) City or town Macon
 (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 all her life
 years, months or days

3. (a) PRINT FULL NAME Mary Elizabeth Delaney
 3. (b) If veteran, name war _____
 3. (c) Social Security No. _____

4. Sex Female
 5. Color or race W
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband E. J. Delaney
 6. (c) Age of husband or wife if alive 72 years
 7. Birth date of deceased Sept 24 1870
 (Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 7
 If less than one day hr. _____ min. _____

9. Birthplace Macon Co., Mo.
 (City, town, or county) (State or foreign country)
 10. Usual occupation House wife

MOTHER FATHER { 12. Name Benjamin Oliver
 13. Birthplace Macon Co., Mo.
 (City, town, or county) (State or foreign country)
 14. Maiden name Annice Mc Gee
 15. Birthplace Ky.
 (City, town, or county) (State or foreign country)

16. (a) Informant M. E. Delaney
 (b) Address Macon Mo
 17. (a) Burial (b) Date thereof 10-28-40
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Catholic Cemetery
 18. (a) Signature of funeral director Stephen Gooding
 (b) Address Macon Mo
 19. (a) 11/7/40 (b) 3027 Hunter
 (Date received local Registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Macon
 (c) City or town Macon
 (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 Oct. day 26
 year 1940 hour 7 minute 45 P.M.
 21. I hereby certify that I attended the deceased from Oct 15 1940 to Oct 26 1940
 that I last saw him alive on _____ 19____;
 and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia
 Due to Nephritis
 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?
 4-1
 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature E. D. Edwards (M. D. or other) _____
 Address 123 1/2 Lane Date signed 11/5/40

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SEP 22 1954

RECEIVED

District Health Officer No. 10.

District File Number 11-40-2122

Date Filed NOV. 13 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

Registered Apprentice No.

working under my personal supervision.

Signed

C. L. Stephens

Licensed Embalmer No.

3057

P. O. Address

Macon, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **35777**
Registrar's No. **64**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **533**

Primary Registration District No. **3027**

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

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Macon
(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.
In this community _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Elizabeth Delaney
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex F 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. (Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 2
If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 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 (Month) (Day) (Year)
(Burial, cremation, or removal)
(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) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Oct day 26
year _____ hour _____ minute _____ M.

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

Immediate cause of death Bronchial pneumonia

Due to nephritis Chronic

Due to _____

Other conditions (Include pregnancy within 3 months of death) 1.2.1

Major findings: Of operations _____
Of autopsy _____
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. D. Edwards (M. D. or other) DO
Address Macon, Mo. Date signed 11/15/48

SUPPLEMENT

