

0. 2
10-39
7-39
K21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27631
Registrar's No. 230

JUG 29 1941

Primary Registration District No. 1

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

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Keokukville, Mo.
(c) Name of hospital or institution: O. Grinn - Smith Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 days
(Specify whether)

3. (a) PRINT FULL NAME MARGARET SCANLAK
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 W
6. (b) Name of husband or wife MARGARET 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased June 22 1856
(Month) (Day) (Year)

8. AGE: Years 35 Months 1 Days 7 If less than one day hr. 4 min. 4

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

10. Usual occupation HOUSEWIFE

11. Industry or business _____

MOTHER FATHER { 12. Name W. M. Lyons
18. Birthplace Ireland 4
(City, town, or county) (State or foreign country)
14. Maiden name Do not know
15. Birthplace Ireland 4
(City, town, or county) (State or foreign country)

16. (a) Informant Miss Kathleen Lyon
(b) Address _____

17. (a) Burial (b) Date thereof Aug 6 - 41
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation St. Joseph - Edina MO

18. (a) Signature of funeral director Paul G. Kriegerbauer
(b) Address Edina, Mo.

19. (a) Aug 7, 1941 (b) Spencer L. Freeman
(Date received by registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Knox
(c) City or town Edina
(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. 1 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 4th
year 1941 hour 6 minute 50 P.M.

21. I hereby certify that I attended the deceased from July 24, 1941, to Aug 4, 1941
that I last saw her alive on Aug 40, 1941
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic myocarditis several years
Chronic nephritis years

Due to _____
Due to _____

Other conditions: Senility 13/16
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

Duration
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 Spencer L. Freeman (M. D. or other) MD
Address Keokukville, Mo. Date signed 8/5/41

RECEIVED

District Health Officer No. 10

District File Number 8-41-1563

Date Filed AUG 21 1941

DL

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 Paul C. Krieghauser

Licensed Embalmer No. 4085

P. O. Address Edina, 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 27631
Registrar's No. 230

Registration District No. 1

Primary Registration District No. 1

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(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 _____ (Specify whether _____)
years, months or days

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 _____

3. (a) PRINT FULL NAME Margaret Scanlan

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

4. Sex F 5. Color or race Wh 6. (a) Single, widowed, married, divorced Shd

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 _____ Months _____ Days _____ (If less than one day _____ min.)

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

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 Miss Kathleen Lyon

(b) Address Adina, Mo.

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Oct. 3, 1941 (b) Spencer L. Freeman

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Year 1941 Hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

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

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)

(b) 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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

