

FILED SEP 15 1942

State File No. ....

Registration District No. 175

Primary Registration District No. 5649

Registrar's No. 100

1. PLACE OF DEATH  
(a) County Lawrence  
(b) City or town Dorsea Sup  
(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) 50 years

3. (a) PRINT FULL NAME Anna Jane Mulrean  
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 Widowed  
6. (b) Name of husband or wife .....  
6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased June 5th 1893  
(Month) (Day) (Year)

8. AGE: Years 29 Months 1 Days 30  
If less than one day ..... hr. .... min.

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

10. Usual occupation House Work

MOTHER FATHER  
11. Industry or business .....  
12. Name Thomas Banahan  
13. Birthplace Ireland (City, town or county) (State or foreign country)  
14. Maiden name Elyzabet Cunningham  
15. Birthplace England (City, town or county) (State or foreign country)

16. (a) Informant Bernard Mulrean  
(b) Address Monett mo

17. (a) (Burial, cremation, or removal) ..... (b) Date thereof Aug 4 1942  
(Month) (Day) (Year)  
(c) Place of burial or cremation St. Patrick's Church

18. (a) Signature of funeral director John Small Jr.  
(b) Address Gene City mo

19. (a) Aug 3 1942 (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County Lawrence  
(c) City or town Rural Monett mo  
(If outside city or town limits, write "RURAL")  
(d) Street No. .... (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 2  
year 1942 hour 12 minute 20 P.M.

21. I hereby certify that I attended the deceased from June  
1942 to Aug 2 1942  
that I last saw her alive on Aug 1 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion  
Due to hypertension + cerebral hemorrhage  
Duration 3 hrs

Other conditions (Include pregnancy within 3 months of death) 940

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?  
(Specify type of place) (e) Means of injury 0

23. Signature F. J. Marmstrong (M. D.)  
Address Monett mo Date signed 8/2/42

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

RECEIVED

District Health Officer No. 6,

District File Number 942-1388

Date Filed SEP 11 1942

RECORDED  
SEP 20 1958

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 me,  
....., Registered Apprentice No. ....  
working under my personal supervision.

Signed

Wm. Mossell Jr.  
Licensed Embalmer No. 1512  
P. O. Address Blaine City Mo

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

If this body is not embalmed, fact should be so stated above.

B  
-41  
9288

Registration District No. 175

Primary Registration District No. 5649

Registrar's No. 100

1. PLACE OF DEATH:

(a) County Lawrence

(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 \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Anna Jane Mulrenic

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

7. Birth date of deceased. June 3  
(Month) (Day) (Year)

8. AGE: Years 29 Months 1 Days 30 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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) Carrie Brown  
(Date received local registrar) (Registrar's signature) 4/21/47

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 Aug Day \_\_\_\_\_ Year 1947 Hour \_\_\_\_\_ Minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I saw \_\_\_\_\_ 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)

(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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

