

Registration District No. **149**

Primary Registration District No. **1002**

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

1. PLACE OF DEATH:

(a) County **Jackson**

(b) City or town **Kansas City**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
123 North Lawndale,
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **11 Months**
(Specify whether years, months or days)

In this community **175 Years**
(Specify whether years, months or 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. **123 N. Lawndale**
(If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **—**

3. (a) PRINT FULL NAME **LYDIA OMA DELANEY**

3. (b) If veteran, name war **No** 3. (c) Social Security No. **None**

4. Sex **Fe.** 5. Color or race **White** 6. (a) Single, widowed, married, divorced, **Widow**

6. (b) Name of husband or wife **Dennis** 6. (c) Age of husband or wife if alive **—** years

7. Birth date of deceased **August 5, 1886**
(Month) (Day) (Year)

8. AGE: Years **57** Months **0** Days **12** If less than one day **11** hr. min.

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

10. Usual occupation **Homemaker**

11. Industry or business **None**

12. Name **John J. Sellers**

13. Birthplace **Kentucky**
(City, town, or county) (State or foreign country)

14. Maiden name **Lottie Metcalf**

15. Birthplace **Ky.**
(City, town, or county) (State or foreign country)

16. (a) Informant **P. F. Mitchum**
(b) Address **909 Kansas.**

17. (a) **Removal** (b) Date thereof **August 19,**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Nat'l Cem. Leavenworth, Kas.**

18. (a) Signature of funeral director **C. H. Blackman & Son, Inc.**
(b) Address **Kansas City, Mo.**

19. (a) **8-18-43** (b) **P. E. Brown**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **8** day **16th**
year **1943** hour **1130** minute **—** P.M.

21. I hereby certify that I attended the deceased from **May** 19**40** to **Aug** 19**43**;
that I last saw her alive on **Aug - 16th** 19**43**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute myocardial insufficiency 2 hrs**

Due to **Arteriosclerosis** 3 yrs

Due to **Essential Hypertension**

Other conditions (Include pregnancy within 3 months of death) **93e**

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? **—**

23. Signature **Wm Fowler** (M. D. or other) **—**
Address **3504 Troost** Date signed **8/16/43**

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.....

B. H. Blackman

Licensed Embalmer No. *2244*

P. O. Address.....

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.