

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 12620
Registrar's No. 85

FILED APR 17 1945

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair

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

(c) Name of hospital or institution:
Community Nursing Home #4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 years
(Specify whether years, months or days)

In this community 2 months & 11 days
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Anna 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 single

6. (b) Name of husband or wife _____

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

7. Birth date of deceased. 4 8 1866
(Month) (Day) (Year)

8. AGE: Years 89 Months 11 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation house keeping

11. Industry or business _____

12. Name Michael Delaney

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

14. Maiden name Anna Pfefferman

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

16. (a) Informant John Delaney

(b) Address Baring, Mo.

17. (a) Burial (b) Date thereof 3-28-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baring, Mo.

18. (a) Signature of funeral director J. B. Kelly

(b) Address Adena, Mo.

19. (a) 4-2-45 (b) Dr. J. W. Wagoner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County KNOX

(c) City or town BARING
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 26
year 1945 hour 7 minute _____ A.M.

21. I hereby certify that I attended the deceased from May 2
1945 to March 26 1945
that I last saw her alive on March 25 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Peripheral Circulatory Collapse Duration 1 day

Due to Uremic poisoning 7 days

Due to Chronic Nephritis ?

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

Major findings:
- Of operations _____

Of autopsy 131:15

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. T. Luteneker (Physician or other) D.O.
Address Traskville, Mo. Date signed 3-26-45

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

MOTHER FATHER

1044

RECEIVED

District Health Officer No. 10

District File Number 4-45-666

Date Filed APR 13 1945

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.....

Licensed Embalmer No. 3155

P. O. Address Haidland M.

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.