

FILED JAN 9 1947  
Registration District No. 360

Primary Registration District No. 6225

State File No. \_\_\_\_\_  
Registrar's No. 167

1. PLACE OF DEATH:

(a) County Merion

(b) City or town Forest Washington

(c) Name of hospital or institution: State Hospital #3 2  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 yr 5 mo - 1 day  
(Specify whether years, months or days)

In this community 1 year 5 months 1 day

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson

(c) City or town Kennett  
(If outside city or town limits, write "RURAL")

(d) Street No. 3204 Penn.  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME JULIA DARBY CLEARY

(b) If veteran, name war No

(c) Social Security No. ✓

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month dec day 28  
year 1946 hour 11 minute 30 a.m.

21. I hereby certify that I attended the deceased from 7-27-46  
to 12-28-46  
that I last saw her alive on 12-28- 1946  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased 11-1-1868  
(Month) (Day) (Year)

Immediate cause of death Arteriosclerosis

Due to ✓

Due to ✓

Other conditions Senile deterioration  
(Include pregnancy within 3 months of death)

Major findings: ✓

Of operations ✓

Of autopsy ✓

Duration

8. AGE: Year 78 Months 1 Days 27  
78 hr. min.

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

10. Usual occupation house

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Patrick Darby

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

14. Maiden name Ellen Coleman

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant Hospital record

(b) Address Nevada Mo

17. (a) Burial (b) Date thereof 12-31-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Boonville mo

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? \_\_\_\_\_

18. (a) Signature of funeral director N. B. Langford

(b) Address Lee's Summit mo

19. (a) 12-31-46 (b) Ruthyn Yancey  
(Date received local registrar) (Registrar's signature)

23. Signature R. G. Hall (M.D. or other) M.D.  
Address Nevada mo 12-28-46 Date signed

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

4210

384 do Wash

LT-C-1

12-15-305

**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 W. B. Longford

Licensed Embalmer No. 3833

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.