

No. 2  
12-45  
-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
**FILED JUN 17 1947**  
Registration District No. 71

THE STATE BOARD OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**  
Primary Registration District No. 3012

State File No. 20347  
Registrar's No. 835

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Excelsior Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 8 days (Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Rose Devine  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_

4. Sex F 5. Color or race W  
6. (a) Single, widowed, married, divorced W  
7. Birth date of deceased: Mar 3 1868  
(Month) (Day) (Year)  
8. AGE: Years 79 Months 2 Days 28 If less than one day hr. min.

9. Birthplace Iowa  
(City, town, or county) (State or foreign country)  
10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_  
12. Name Patrick O'Brine  
13. Birthplace New York  
(City, town, or county) (State or foreign country)  
14. Maiden name Mary Lantry  
15. Birthplace Ireland  
(City, town, or county) (State or foreign country)

16. (a) Informant Daniel A. Devine  
(b) Address 3117 Summit Kansas City, Mo  
17. (a) Removal (b) Date thereof 6-2-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove, Kansas  
18. (a) Signature of funeral director Claude S. ...  
(b) Address Excelsior Springs, Mo  
19. (a) 6/3/47 (b) Caroline Hutchings  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Clay 24  
(c) City or town Excelsior Springs  
(If outside city or town limits, write "RURAL")  
(d) Street No. 545 Old Orchard  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month June day 15  
year 1947 hour 9 minute 10 P.M.  
21. I hereby certify that I attended the deceased from 25 May 1947 to 1st June 1947  
that I last saw her alive on 1st June 1947  
and that death occurred on the date and hour stated above.  
Immediate cause of death: Mesencephalic thrombosis Duration 6 days  
Myocardial infarction 3 days  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: 94A  
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 C. B. ... (M. D. or other) M. D.  
Address Excelsior Springs, Mo Date signed 6/2/47

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number \_\_\_\_\_

Date Filed 6-16-87

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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 Robert Ray

Licensed Embalmer No. 4182

P. O. Address Excelsior Springs, 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, fact should be so stated above.**