

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **232**

1. PLACE OF DEATH:

(a) County **ADAIR**
(b) City or town **KIRKSVILLE**
(c) Name of hospital or institution: _____
(If outside city or town limits, write "RURAL" and name of township)
(If not in hospital or institution, write street number or location) ✓
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **6 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **ADAIR** 3
(c) City or town **KIRKSVILLE** 3
(If outside city or town limits, write "RURAL")
(d) Street No. **606 E. HARRISON ST** 0
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT FULL NAME **ANNA KILBRIDE DALY**

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 **MARRIED**
6. (b) Name of husband or wife **DENNIS DALY** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **NOVEMBER 10 1874**
(Month) (Day) (Year)

8. AGE: Years **73** Months **8** Days **24** If less than one day _____ hr. _____ min.

9. Birthplace **KNOX COUNTY MISSOURI**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business _____

MOTHER FATHER { 12. Name **TIMOTHY KILBRIDE**
13. Birthplace **IOWA** 1
(City, town, or county) (State or foreign country)
14. Maiden name **MARY CLARK**
15. Birthplace **OHIO** 1
(City, town, or county) (State or foreign country)

16. (a) Informant **DENNIS DALY**
(b) Address **606 E. HARRISON - KIRKSVILLE MO**

17. (a) **BURIAL** (b) Date thereof **AUG - 6 - 1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **ST. MARY'S - ADAIR - MO**

18. (a) Signature of funeral director **Foster R. Easley**
(b) Address **Brookway Missouri**

19. (a) **8-11-48** (b) **Hate Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **August** day **4th**
year **1948** hour **11:00** minute **15** A. M.

21. I hereby certify that I attended the deceased from **Feb. 14th** 19**48**, to **August 4**, 19**48**, that I last saw her alive on **August 4th**, 19**48**, and that death occurred on the date and hour stated above.

Immediate cause of death **Malignant growth of stomach**

Due to _____

Due to **H₂O**

Other conditions (Include pregnancy within 3 months of death)

Major findings: **Epileptory - Inoperable malignant mass of stomach**
Of operations _____
Of autopsy **No pathological study was made**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury **2**

23. Signature **N. Sue Grasse** (M. D. or other) **P.O.**
Address **Kirkville, Mo** Date signed **Aug. 10 1948**

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

RECEIVED

District Health Officer No. 10

District File Number 8-48-14

Date Filed AUG 17 1948

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 Geo. Blasberg

Licensed Embalmer No. 3755

P. O. Address Furdent. W.

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

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