

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

AUG 20 1935

23144

1. PLACE OF DEATH
 County Jackson Registration District No. 399 File No. _____
 Township Raw Primary Registration District No. 1002 Registered No. _____
 City Kansas City (No. Rock Island Golden State L.L. St. Ward) _____
Enroute to Kansas City

2. FULL NAME Florence Delaney
 (a) Residence, No. 3932 Chestnut St., _____ Ward. _____
 (Usual place of abode) _____ (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF, _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 14-1913

7. AGE YEARS 22 MONTHS 6 DAYS _____ If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. at home
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Mo

MOTHER FATHER
 13. NAME John A. Delaney
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo
 15. MAIDEN NAME Florence Larkin
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Mrs. Florence Delaney (ADDRESS) 3932 Chestnut

18. BURIAL, CREMATION, OR REMOVAL
 PLACE M. S. Wade's DATE July 17 35

19. UNDERTAKER J. F. O'Connell Co (ADDRESS) 5256 Broadway

20. FILED July 18 1935 M. M. Cronin Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7/15/35 1935

22. I HEREBY CERTIFY that I attended deceased from _____, 19____
Dr. J. P. Cronin
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.
 The principal cause of death and related causes of importance were as follows:
3 Tuberculosis Date of onset _____

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external cause (violence), fill in also the following:
 Accident, suicide, or homicide: _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) [Signature] _____, M. D.
 (Address) _____

