

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

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.

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

37791

State File No. _____

Registrar's No. _____

9630

Registration District No. _____

791

Primary Registration District No. _____

1. PLACE OF DEATH:

1003

2

- (a) County _____
 (b) City or town 3972 McRee St. Linn Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution 3972 McRee St
 (Specify whether _____)

In this community 42 years
 years, months or days

3. (a) PRINT FULL NAME

CATHERINE V. McAnany

3. (b) If veteran, name war _____

3. (c) Social Security No. 493-05-5190

4. Sex Female 5. Color or race White
 6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife Chas McAnany
 6. (c) Age of husband or wife if alive 44 years

7. Birth date of deceased Nov 13 1897
 (Month) (Day) (Year)

8. AGE: Years 46 Months 11 Days 26
 If less than one day hr. _____ min. _____

9. Birthplace St. Linn Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation House wif 0

11. Industry or business _____ 0

12. Name John J. McAnany 5

13. Birthplace St. Linn Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name in my German

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

16. (a) Informant's own signature Chas McAnany

- (b) Address 3972 McRee Ave

17. (a) _____ (b) Date thereof 11-11-39
 (Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation Calvary Church

18. (a) Signature of funeral director John Bolton Bur

- (b) Address 928 N Grand Blvd

19. (a) NOV 11 1939 (b) J. F. Bredect
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State _____ (b) County _____

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

- (d) Street No. 3972 McRee Ave
 (If rural, give location)

- (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. 9 day 9th
 year 1939 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from May 1939, to Nov. 9 1939;
 that I last saw her alive on Nov. 9 1939;
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma sigmoid colon

Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

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 _____

23. Signature Edward R. Sheridan (M. D. or other) M.D.
 Address 2602 So. Grand Date signed 11-10-39

1008

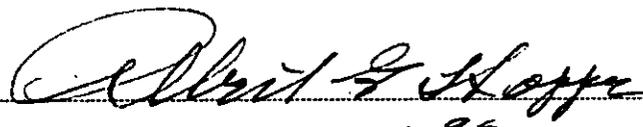
STATEMENT BY LICENSED EMBALMER

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. 2991

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, above space should be left blank.