

2  
3-40  
-39  
(23189)

Registration District No. 26

Primary Registration District No. 3002

State File No. \_\_\_\_\_

Registrar's No. 83

1. PLACE OF DEATH:

(a) County Audrain

(b) City or town Mexico  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Audrain Co Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 7 days  
(Specify whether In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Audrain

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

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

3. (a) PRINT FULL NAME MARY AGNEW QUINN 506

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. none

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th.  
year 1940 hour Nine minute 15-A. M.

4. Sex female

5. Color or race White

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

6. (b) Name of husband or wife Michael Quinn

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

7. Birth date of deceased March 31 - 1858  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 24, 1940 to June 30, 1940  
that I last saw her alive on June 30, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Fracture left humerus and dislocation left shoulder

Duration 6-Days

8. AGE:

Years	Months	Days	If less than one day
<u>82</u>	<u>3</u>	<u>0</u>	hr. _____ min. _____

Due to Fall in home

Due to \_\_\_\_\_

Other conditions Arterio-Sclerosis  
(Include pregnancy within 3 months of death)

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

10. Usual occupation Retired House-wife

11. Industry or business Home

12. Name William Agnew

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

14. Maiden name Mancy McCabe

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

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

MOTHER FATHER

16. (a) Informant Mrs. Muriel Cragg

(b) Address Ladonia Mo

17. (a) Burial (b) Date thereof July 2-40  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ladonia, Mo

18. (a) Signature of funeral director H. J. Trainger 2

(b) Address Ladonia Mo

19. (a) June 30 1940 (b) Blanche Neely  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence June 24-1940

(c) Where did injury occur? Ladonia Audrain Mo.  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home

While at work? No (Specify type of place) (e) Means of injury Fall

23. Signature W. K. McCall (M. D. or other) !  
Address Ladonia MO Date signed 7-1-4

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

W.C.O. NEW YORK

RECEIVED

District Health Officer No. 10

District File Number 7-40-1385

Date Filed JUL 10 1940

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.....

*H. G. Granger*

Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*H. G. Granger*

Licensed Embalmer No. ....

*1297*

P. O. Address.....

*Saddonia N.Y.*

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.