

JUL 12 1940

Registration District No. **496**

Primary Registration District No. **3025**

Registrar's No. **53**

1. PLACE OF DEATH:

(a) County Linn
 (b) City or town Brookfield, Mo
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: The Barney Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 3 days (Specify whether
 In this community _____ years, months or days) ERT

3. (a) PRINT FULL NAME Luther Logan Mahaney
 3. (b) If veteran, name war — 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Rula Mahaney 6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased: April 17 1864
 (Month) (Day) (Year)

8. AGE: Years 66 Months 6 Days 4 If less than one day hr. min.

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

10. Usual occupation Mail Messenger

11. Industry or business Post office dept.

MOTHER FATHER { 12. Name Napoleon Mahaney

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

14. Maiden name Emma Calvert
 (City, town, or county) (State or foreign country)

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

16. (a) Informant's own signature Marjorie M. Bowring
 (b) Address Kansas City, Mo

17. (a) Burial (b) Date thereof June 16, 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mc Cullough Cem, Tripletts Mo

18. (a) Signature of funeral director Crotts & Wright
 (b) Address Tripletts, Mo.
 19. (a) June 16 40 (b) Moorehead
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Chariton
 (c) City or town Tripletts
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 14
 year 1940 hour 8 minute 00 A.M.

21. I hereby certify that I attended the deceased from JUNE 7, 1940, to JUNE 13, 1940;
 that I last saw him alive on JUNE 13, 1940;
 and that death occurred on the date and hour stated above.

Immediate cause of death GENERAL PERITONITIS Duration 3 DAYS

Due to RUPTURE OF ILEUM 3 DAYS

Due to SCIRRHOUS CARCINOMA AT ILEOCECAL JUNCTION (PRIMARY) UNK

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H/D

Of autopsy _____

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 Kenneth B. Brumance (M. D. or other) Dr
 Address TRIPLETTS MO Date signed 6-14-40

Duration

3 DAYS

3 DAYS

UNK

PHYSICIAN

Underline the cause to which death should be charged statistically

WHILE FILLING OUT THIS FORM USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

I 10851

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.

RECEIVED
District Health Officer No. 11,
District File Number 742-982
Date Filed JUL 2 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.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed H. B. Wright

Licensed Embalmer No. 3718

P. O. Address Brookfield, 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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 22180

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 496

Primary Registration District No. 3025-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Linn
(b) City or town Brunswick
(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 _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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

Luther Logan Mahaney

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 14
year _____ hour _____ minute _____ M.

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 5. Color or race w

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

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased: apr 12 1864
(Month) (Day) (Year)

8. AGE: Years 64 Months 2 Days 2 If less than one day _____ hr. _____ min.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

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 H. L. Rosencrance (D. or other) _____

Address Truitt _____ Date signed _____

MOTHER FATHER

11. Industry or business _____

12. Name _____

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

14. Maiden name _____ (City, town, or county) _____ (State or foreign country)

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 8-3-40 (Date received local registrar) (b) [Signature] (Registrar's signature)

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

SUPPLEMENTARY

