

Registration District No. 5-31

Primary Registration District No. 5718

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon
 (b) City or town Rural Russell - Mo 9
 (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 None
 (Specify whether
 In this community Life
 years, months or days)

3. (a) PRINT FULL NAME DELANEY LUCY STANFIELD

8. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
 7. Birth date of deceased November 4 1867
 (Month) (Day) (Year)

8. AGE: Years 72 Months 6 Days 13 If less than one day hr. _____ min. _____

9. Birthplace Russell township Macon Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business _____

12. Name John Millhap S

13. Birthplace _____ ✓

14. Maiden name Sarah Lovett S

15. Birthplace _____ S

16. (a) Informant Mrs Geo R Tuttle

(b) Address Kansas City

17. (a) _____ (b) Date thereof May 19 1940
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cath Cemetery

18. (a) Signature of funeral director H. J. Hillland

(b) Address New Canaan, Mo.

19. (a) _____ (b) J. C. Sheppard
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Macon
 (c) City or town Bucklin Rural
 (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 May day 17
 year 1940 hour 04 minute 55 A. M.

21. I hereby certify that I attended the deceased from 8/11, 1934, to 5/17, 1940,
 that I last saw her alive on 5/17, 1940,
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis
 Due to Chronic Interstitial Nephritis

Due to HF

Other conditions (include pregnancy within 3 months of death) 131

Major findings: Of operations _____
 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?
474 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____

23. Signature W. L. Spear (M. D. or other) DO
 Address: Bucklin Mo. Date signed 5/17/40

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

RECEIVED

District Health Officer No. 10

District File Number 8-46-1660

Date Filed AUG 17 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. J. Gilleland

Licensed Embalmer No. 4019

P. O. Address New Cambria, 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.