

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

**41977**  
 Do not use this space.

FILED JAN 13 1941

**1. PLACE OF DEATH**

(a) County Buster Registration District No. 89  
 (b) Township Neely Rural Primary Registration District No. 5130  
 (c) City \_\_\_\_\_ (d) Street No. \_\_\_\_\_ St. \_\_\_\_\_  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME** Lauren Homer Delaney

(a) Residence, No. \_\_\_\_\_ St. 7  
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Sarah Delaney  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 8, 1895  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. ✓  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Dec 6, 1940

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 1932, to Dec 10, 1940

I last saw him alive on Dec 1, 1940 Death is said to have occurred on the date stated above, at 10:30 a.m.

The principal cause of death and related causes of importance were as follows:

pulmonary tuberculosis  
23  
 Date of onset \_\_\_\_\_

Other contributory causes of importance:  
pyelitis with emphysema

Name of operation tube to drainage Date of 1940  
 What test confirmed diagnosis? histology of spleen & biopsy No

23. If death was due to external causes (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? No  
 If so, specify \_\_\_\_\_

(Signed) Hughes M. D.  
 (Address) Naylor Mo

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marquand Mo.

13. NAME Wm. F. M. Delaney

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown Kansas (?)

15. MAIDEN NAME Anna Anthony

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Frederick Mo

17. INFORMANT (ADDRESS) Mrs. Flora Poe Naylor Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Rivley Ceme DATE Dec 9 1940

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Minnie Leah Naylor Mo.

20. FILED 12/18 1940 Kate Lutz Local Registrar.

WRITE PLAINLY, WITH UNFADING INK---THIS IS 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.

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**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 *Dwight Mc Card*  
Licensed Embalmer No. *4029*  
P. O. Address *Naylor, 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.**

FILED FEB 17 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 41977

Registration District No. 89

Primary Registration District No. 2130

Registrar's No. 371

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

1. PLACE OF DEATH:

(a) County Butler  
(b) City or town Neely  
(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 \_\_\_\_\_ (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Butler  
(c) City or town HARVIELL "RURAL"  
(If outside city or town limits write "RURAL")  
(d) Street No. Route 14 (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

3. (a) PRINT FULL NAME Lauren Homer Delaney

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 m

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

7. Birth date of deceased Oct 8 1890  
(Month) (Day) (Year)

8. AGE: Years 50 Months 1 Days 28 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) 2/12/41 (b) Kate Lutz  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 6  
year \_\_\_\_\_ hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h. \_\_\_\_\_ 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 \_\_\_\_\_

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. E. White (M. D. or other) \_\_\_\_\_

Address Harviell Mo. Date signed \_\_\_\_\_

Duration  
PHYSICIAN  
Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

