

JAN 17 1941

Registration District No. 461

Primary Registration District No. 3024

1. PLACE OF DEATH:

(a) County Lafayette

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

(c) Name of hospital or institution:
18th & Taylor
(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 Lafayette

(c) City or town Lexington
(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 John Alexander Delana

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. day 27
year 1940 hour 6 minute 30 P.M.

4. Sex Male

5. Color or race white

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased Feb. 22 1848
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from _____, 19____, to Dec 27, 1940;
that I last saw him alive on Dec 1st, 1940
and that death occurred on the date and hour stated above.
Immediate cause of death Atherosclerosis
& shock resulting from
a fall 3 weeks previous
Due to to death

8. AGE:

Years	Months	Days	If less than one day
<u>98</u>	<u>11</u>	<u>5</u>	hr. _____ min. _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy _____

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

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER {

12. Name Not Known

13. Birthplace Not Known
(City, town, or county) (State or foreign country)

14. Maiden name Not Known

15. Birthplace Not Known
(City, town, or county) (State or foreign country)

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant Mrs. Robert Register

(b) Address Lexington, Mo.

17. (a) Burial (b) Date thereof Dec. 29, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Dover

18. (a) Signature of funeral director Winkler

(b) Address Lexington, Mo.

19. (a) Dec 29/40 (b) Melia Bates
(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) _____

(b) Date of occurrence _____

(c) Where did injury occur? his home
(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) Means of injury _____

23. Signature OT Ryland (M. D. or other) _____
Address Lexington Mo Date signed 1-4-41

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

461

RECEIVED
District Health Officer No. 8,
District File Number ~~177~~
Date Filed 1-10-41

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. _____

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, fact should be so stated above.