

FILED **STANDARD CERTIFICATE OF DEATH**

State File No. _____

X28390

Registration District No. 1

Primary Registration District No. 3000

Registrar's No. 230

1. PLACE OF DEATH:

(a) County Adair
 (b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
A.S.O. Hospital
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 8 days
(Specify whether
 In this community none
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Ray 52
 (c) City or town Baring 0
(If outside city or town limits, write "RURAL")
 (d) Street No. _____
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME FLORENCE MARGUERITE DELANEY

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

4. Sex F 1 race W 5. Color or race W 6. (a) Single, widowed, married, divorced 1
 6. (b) Name of husband or wife John Alfred Delaney 6. (c) Age of husband or wife alive years
 7. Birth date of deceased Apr 25 1904
(Month) (Day) (Year)

8. AGE: Years 37 Months 11 Days 23 If less than one day
hr. min.

9. Birthplace Edina Knox Co Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Ruford Mc Mahon

13. Birthplace Terre Co Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Anna Hogan

15. Birthplace Blairance Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mary B. McMahon

(b) Address Edina, Mo.

17. (a) Buried (b) Date thereof 8/21/42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Baring Mo.

18. (a) Signature of funeral director Wm Kinghouse

(b) Address Edina, Mo.

19. (a) Aug. 26, 1942 (b) Mrs. J. P. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 18
 year 1942 hour 11 minute 23 P. M.

21. I hereby certify that I attended the deceased from Aug. 12, 1942, to Aug. 18, 1942.

that I last saw her alive on Aug. 18, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis Hemorrhage Duration _____

Due to Hydatidiform Mole

Due to Abdominal Hysterotomy

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 [Signature] (M. or S. Dr.)

Address [Address] Date signed [Date]

1047 (Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

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

RECEIVED

District Health Officer No. 10

District File Number 9-42-1699

Date Filed SEP - 8 1942

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 Keith Hudson
Licensed Embalmer No. 2415
P. O. Address Edina, Minnesota

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 26547
Registrar's No. 230

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Keokuk
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: A.S.O. Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days
In this community years, months or days (Specify whether)

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) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Florence M Delaney

3. (b) If veteran, name war I-1 3. (c) Social Security No.

4. Sex F 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 25 years (Month) (Day) (Year)

7. Birth date of deceased Sept 25 1914 (Month) (Day) (Year)

8. AGE: Years 37 Months 11 Days 03 min. If less than one day

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

10. Usual occupation

11. Industry of 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) (b) (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug year 1942 hour minute M.

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

Immediate cause of death Chronic myocarditis Duration

hemorrhage

Due to Hydatidiform mole

Due to abdominal hysterectomy

Other conditions (Include pregnancy within 3 months of death)

139 lb

Major findings: Of operations Hydatidiform Mole

Of autopsy no malignancy

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 J. H. Delaney, D.O. (M. D. or other)

Address Keokuk Date signed

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

SUPPLEMENTARY

