

ED MAY 10 1943

Registration District No. 282

Primary Registration District No. ~~282~~ 5971

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Lolk  
(b) City or town Bolivar Rural (Marion)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution.....  
In this community 1 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lolk  
(c) City or town Bolivar Rural  
(d) Street No. 4 miles west of Bolivar  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

3. (a) PRINT FULL NAME

Olta May Delaney

3. (b) If veteran, name war

None

3. (c) Social Security No.

None

4. Sex

Female

5. Color or race

White

6. (a) Single, widowed, married

Divorced Married

6. (b) Name of husband or wife

Robert Earl Delaney

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

53 years

7. Birth date of deceased

May 10, 1889

8. AGE:

Years 53 Months 10 Days 18  
If less than one day hr. min.

9. Birthplace

Florida Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation

House Keeper

11. Industry or business

House work

MOTHER FATHER

12. Name  
13. Birthplace  
14. Maiden name  
15. Birthplace

H. M. C. Dusevichschou  
Hamburg Germany  
Elizabeth Ulmer  
Germany

16. (a) Informant

Robert E. Delaney

(b) Address

Bolivar, Mo.

17. (a) Date of burial

April 3, 1943

(b) Date thereof

(c) Place: burial or cremation

near Paris, Mo.

18. (a) Signature of funeral director

Edward S. Blue

(b) Address

Bolivar, Mo.

19. (a) Date received local registrar

Apr 2, 1943

(b) Registrar's signature

Alice Palen

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May, day 28, year 1943 hour 3:15 minute 2 M.

21. I hereby certify that I attended the deceased a few minutes after death in a convulsion and that death occurred on the date and hour stated above.

Immediate cause of death caused from a tumor on brain

Due to.....  
Due to.....

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

Major findings: Brain tumor

Of operations.....  
Of autopsy.....

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?.....  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?..... (Specify type of place)  
(c) Means of injury.....

23. Signature J. M. Bridges or other

Address Bolivar, Mo. Date signed 4/2-1943

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

FEB 23 1955

RECEIVED

District Health Officer No. 7,

District File Number 4-43-141

Date Filed 5-4-43

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 William B. Ewin

Licensed Embalmer No. 3092

P. O. Address Polina 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 15-128

Registration District No. 282

Primary Registration District No. 5-971

Registrar's No. 12

1. PLACE OF DEATH:

(a) County Palk

(b) City or town Rural  
(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 \_\_\_\_\_ years, months or days) 1 yr

2. USUAL RESIDENCE OF DECEASED:

(a) State mo (b) County Palk

(c) City or town Rural  
(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 Alta M Delaney

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month mar day 3 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

4. Sex 7 5. Color or race m 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife Robert Earl 6. (c) Age of husband or wife if alive 5-3 years

7. Birth date of deceased may 10 (Month) (Day) (Year)

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_

8. AGE: Years 5-3 Months 10 Days \_\_\_\_\_ (if less than one day) min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

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)

Major findings: Tumor on Brain

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(Burial, cremation, or removal)

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

(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 \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

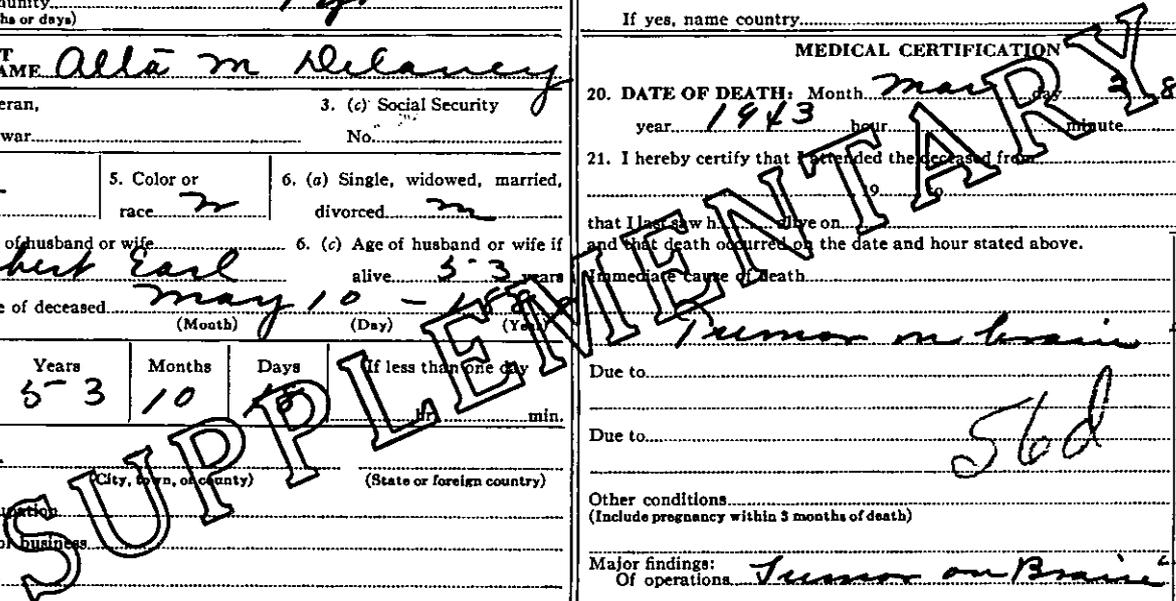
Address \_\_\_\_\_ Date signed \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

(Date received local registrar)

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

MOTHER FATHER



S-15128