S. No. 2
0M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 16895

FILED JUN 7 1943

Registration District No. 45

Primary Registration District No. 1002

Registrar's No. 2431

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: 3303 Troost 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community 3 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 3303 Troost 8
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country None

3. (a) PRINT FULL NAME John A. Delaney

3. (b) If veteran, name war None

3. (c) Social Security No. 500-01-8996

4. Sex Male 0

5. Color or race Wh

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife None

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

7. Birth date of deceased Dec 7 1885 (Month) (Day) (Year)

8. AGE: Years 57 Months 5 Days 18 If less than one day ..... hr. ..... min.

9. Birthplace Centerview Mo (City, town, or county) 0 (State or foreign country)

10. Usual occupation Carpenter

11. Industry or business

FATHER
12. Name Wm. R. Delaney
13. Birthplace Ill (City, town, or county) i (State or foreign country)

MOTHER
14. Maiden name Susan Ozias
15. Birthplace Ohio (City, town, or county) P (State or foreign country)

16. (a) Informant James B. Delaney
(b) Address Centerview Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 5-26 43 (Month) (Day) (Year)
(c) Place: burial or cremation Centerville Mo

18. (a) Signature of funeral director Harlyn Koz
(b) Address 7406 Wornall Rd

19. (a) 1/28/43 (Date received by local registrar) (b) M. M. Brown (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 25 year 1943 hour ..... minute ..... M.

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

Immediate cause of death Arteriosclerotic heart disease

Due to G315

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy Negative

Duration

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature O. J. Stubbs M.D. (Type or other)

Address Date signed 1/28/43

(Licensed Embalmer's Statement on Reverse Side)

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 Harlyn Roe, Registered Apprentice No. ....., working under my personal supervision.

Signed Harlyn Roe

Licensed Embalmer No. 2816

P. O. Address [illegible]

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.