

No. 2  
1-18-40  
-17-39  
X23159

DEPARTMENT OF THE COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

14146

FILED MAY 11 1944  
8542

State File No. \_\_\_\_\_

Registration District No. \_\_\_\_\_

Primary Registration District No. 10011005

Registrar's No. 346

1. PLACE OF DEATH:

(a) County BUCHANAN

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

(c) Name of hospital or institution: MU. METHU. HOSPITAL  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 weeks  
(Specify whether)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME GEORGE M DENNY

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Male 5. Color or race white 6. (a) Single, widowed, married, divorced M

6. (b) Name of husband or wife Malley Denny 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased 4-18-60  
(Month) (Day) (Year)

8. AGE: Years 84 Months 9 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace De Kalb Co MO  
(City, town, or county) (State or foreign country)

10. Usual occupation Carpenter

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

MOTHER FATHER

12. Name Tom Denny

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

14. Maiden name Susan Dillingham

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

16. (a) Informant Mrs. George Denny

(b) Address Marysville Mo

17. (a) Marysville Mo (b) Date thereof 4-1-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Marysville Mo

18. (a) Signature of funeral director John Wilson

(b) Address Marysville Mo

19. (a) 4-7-44 (b) Rae Allegoy  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County De Kalb

(c) City or town Marysville Mo  
(If outside city or town limits write "RURAL")

(d) Street No. no 2  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? 1 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 1 year 1944 hour \_\_\_\_\_ minute 1 P. M.

21. I hereby certify that I attended the deceased from Mar 19 1944 to April 1 1944  
that I last saw him alive on Mar 31 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Hyperacute Pneumonia

Due to degeneration of prostate

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

Other conditions Deathbed medicine  
(Include pregnancy within 3 months of death)

Major findings: Of operations Hyperplasia of Prostate

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

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place)

(e) Means of injury \_\_\_\_\_

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

Address De Kalb St Joseph Mo Date signed 4/1/44

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

12-33

(Licensed Embalmer's Statement on Reverse Side)

JUN 12 1944

MAY 24 1944

**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 John G. Brown

Licensed Embalmer No. 3933

P. O. Address Waysville

**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.**