

S. No. 2
4-13-40
5-17-39
X23159

FILED FEB 6 1945 149

Registration District No. _____ Primary Registration District No. **1002**

Registrar's No. **431**

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution: St. Mary's Hosp
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 40 min
(Specify whether years, months or days)

In this community 40 min

3. (a) PRINT FULL NAME Baby Girl Maloney

3. (b) If veteran, name war no

3. (c) Social Security No. none

4. Sex Female 5. Color or race w

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

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

7. Birth date of deceased: 1-27-45
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ hr. 40 min.

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

10. Usual occupation W. B.

11. Industry or business _____

MOTHER FATHER

12. Name John Joseph Maloney, Jr.

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

14. Maiden name Anna Jean Schloske

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

16. (a) Informant Mr. John Maloney

(b) Address Shawnee, Kans

17. (a) Buried (b) Date thereof Jan 27-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary's Hosp

18. (a) Signature of funeral director W. E. Brown

(b) Address W. E. Brown

19. (a) 1-27-45 (b) W. E. Brown
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **999**

(a) State Kans (b) County Jackson

(c) City or town Shawnee
(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.? 7 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 27
year 1945 hour 7 minute 23 a M.

21. I hereby certify that I attended the deceased from 1-27-1945 to 1-27-1945
that I last saw h. alive on 1-27-1945
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage **40 min.**

Due to Rapid labor.

Due to 430

Other conditions Mild maternal toxemia
(Include pregnancy within 3 months of death)

Major findings: foremed

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? _____ (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 or means of injury)

23. Signature W. E. Brown (M. D. or other) _____
Address 1103 Milan Date signed 1/27/45

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

1
3
8

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.....

Wm L Hard

Licensed Embalmer No.....

3991

P. O. Address.....

309 E. 67

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.)

J. E. Mo.

If this body is not embalmed, fact should be so stated above.