. No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 7 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

28753
State File No.

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 123

1. PLACE OF DEATH

(a) County Vernon
(b) City or town Rural - Washington Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: State Hosp. # 3 2
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 3yrs 10 months (Specify whether years, months or days)
In this community Same

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 3339 Wabash
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Olga A Laherty
3. (b) If veteran, name war No
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 Albert A Laherty
6. (c) Age of husband or wife if alive Dr years
7. Birth date of deceased Aug (Month) 31 (Day) 1894 (Year)

8. AGE: Years	Months	Days	If less than one day
50	11	12	hr. min.

9. Birthplace Kansas City (City, town, or county) Mo (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name August Peterson
13. Birthplace Sweden (City, town, or county) (State or foreign country)
14. Maiden name Victoria Gumberg
15. Birthplace Sweden (City, town, or county) (State or foreign country)
16. (a) Informant Hosp. Rec.
(b) Address Nevada Mo
17. (a) Disposal (Burial, cremation, or removal) (b) Date thereof Aug 14 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Kansas City Mo
18. (a) Signature of funeral director Hays Funeral Service
(b) Address Nevada Mo
19. (a) 8-12-1945 (Date received local registrar) (b) Hazel Bunch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 12 year 1945 hour 09 minute 15 A.M.
21. I hereby certify that I attended the deceased from Oct 9 1941 to Aug 12 1945 that I last saw him alive on Aug 11 1945 and that death occurred on the date and hour stated above.

Immediate cause of death — Duration
Coronary Occlusion
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
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? (Specify type of place)
While at work? (e) Means of injury
23. Signature Wm. J. Cramer (M. D. or other)
Address Nevada Date signed 8/12/45

1831 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 8-45-869
Date Filed 9-5-45

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 H. H. Marmaduke

Licensed Embalmer No. 2072

P. O. Address Nevada 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.

No. 2B
-3-45
X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Sept

Registration District No. 360 Primary Registration District No. 6225 Registrar's No. 123

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County Vernon

(b) City or town Rural Washington Twp
(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 years, months or days)

In this community

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 Olga Flaherty

3. (b) If veteran, name war

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

7. Birth date of deceased Aug 5 1884
(Month) (Day) (Year)

8. AGE: Years 50 Months Days If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business None

MOTHER FATHER

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 9-12-45 (Date received local registrar) (b) Kathryn Yancey (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug Day year 1945 hour minute M.

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

Duration

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
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? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

S-28753