

S. No. 2
DM-543
v. 5-17-39
I X36671

FILED AUG 20 1947

Registration District No. **177**

Primary Registration District No. **5019-5287**

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

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:
Rt. #1, Crecent Lake Addition /
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether
In this community 1 Year _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay **24**

(c) City or town Rural Rt. # 1 **0**
(If outside city or town limits, write "RURAL")

(d) Street No. Excelsior Springs. **0**
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME MARGARET ANN FLEHARTY

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 21st,
year 1947 hour 9 minute 25 P.M.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Wm. H. Fleharty

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

7. Birth date of deceased June 25 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 7/20/47 to 7/21/47, 1947; that I last saw her alive on 7/21/47, 1947; and that death occurred on the date and hour stated above.

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

89 0 26 hr. _____ min.

Immediate cause of death Cerebral Hemorrhage

Due to Arteriosclerosis
Hypertension

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

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

Major findings: Of operations _____

Of autopsy _____

10. Usual occupation At Home

11. Industry or business _____

MOTHER FATHER { 12. Name James Chambers

13. Birthplace Ireland **4**
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Powers

15. Birthplace Ireland **7**
(City, town, or county) (State or foreign country)

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? _____

16. (a) Informant Mrs. Leo Ohlak

(b) Address Rt. # 1, Excelsior Sp'gs. Mo.

17. (a) Removal (b) Date thereof 7/22/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Harwood Missouri

18. (a) Signature of funeral director Claude Trichard

(b) Address Excelsior Springs, Mo.

19. (a) 7/28/1947 (b) Caroline Dultchinsky
(Date received local registrar) (Registrar's signature)

While at work? _____ (Specify type of place) (e) Means of injury _____

Signature Dr. M. Y. ... (M. D. or other) **MS**

Address Excelsior Sp'gs Mo. Date signed 7/22/47

RECEIVED

District Health Officer No. 8,

District File Number 5

Date Filed 8-19-47

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..... *Robert E. White*

Licensed Embalmer No. 4168

P. O. Address Excelsior Springs, 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.