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5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

FILED MAR 3 1948

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

7635

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

Registration District No. 366

Primary Registration District No. 6242

Registrar's No. 23

1. PLACE OF DEATH

(a) County Washington

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

(c) Name of hospital or institution: 3 mi. S.W. of Bluewell No. 1  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_ years, months or days 60 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Washington

(c) City or town Cadet Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. 3 mi. S.W. of Bluewell No.  
(If rural, give location)

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

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME CHARLES HUGH CLANCY

3. (b) If veteran, name war NO

3. (c) Social Security No. NONE

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26  
year 1948 hour 8 minute 15 A.M.

21. I hereby certify that I attended the deceased from 2-25, 1948 to 2-26, 1948  
that I last saw him alive on 2-25, 1948  
and that death occurred on the date and hour stated above.

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced. WIDOWED

6. (b) Name of husband or wife Hannie Clancy 6. (c) Age of husband or wife if alive 22 years

7. Birth date of deceased July 22 1864  
(Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration 18 hrs

8. AGE: Years 83 Months 7 Days 4 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

Other conditions (include pregnancy within 6 months of death) Infermieter of Age

9. Birthplace Ann Arbor Michigan  
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

PHYSICIAN \_\_\_\_\_

Major findings: \_\_\_\_\_

Of operations \_\_\_\_\_

Of autopsy 93P

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

12. Name John Clancy

13. Birthplace Providence R.I.  
(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? \_\_\_\_\_

14. Maiden name Margaret Hildebrand

15. Birthplace Ann Arbor Mich  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. J. J. Knott

(b) Address Cadet Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Feb. 28 1948  
(Month) (Day) (Year)

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury 0

23. Signature Charles H. Clancy (M. D. or other) \_\_\_\_\_  
Address 3-26-48 Date signed 7/24/48

(c) Place: burial or cremation Masonic Cemetery Bluewell

18. (a) Signature of funeral director Donnell B. ...

(b) Address Cadet Mo.

19. (a) 3-26-48 (Data received local registrar) (b) 4.13 (Registrar's signature) 2048

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

110  
0  
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RECEIVED

District Health Officer No. 4  
District File Number 348-309  
Date Filed 3-2-48

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**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 Donnell B. Dietrich

Licensed Embalmer No. 4104

P. O. Address Adato 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.