

1. PLACE OF DEATH:

(a) County... DeKalb  
 (b) City or town... Maysville  
 (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... 9 mo. (Specify whether years, months or days)

3. (a) PRINT FULL NAME... Laura Belle McLaney  
 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... 3 divorced  
 6. (b) Name of husband or wife... Joseph McLaney  
 6. (c) Age of husband or wife if alive... - years  
 7. Birth date of deceased... Sept 25 1878  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
69 9 15 hr. min.

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

10. Usual occupation... Housewife

11. Industry or business:

12. Name... Isaac Green  
 13. Birthplace... Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name... Unknown  
 15. Birthplace... Unknown (City, town, or county) (State or foreign country)

16. (a) Informant... Mrs. Annie Ribbey  
 (b) Address... St. Joseph, Mo.  
 17. (a) B (b) Date thereof... 7-12-48  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation... Stewartville, Mo.

18. (a) Signature of funeral director... Stewartville, Mo.  
 (b) Address... 7-30-48  
 19. (a) 7-30-48 (b) R. Davidson  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State... Missouri (b) County... DeKalb  
 (c) City or town... Maysville, Mo.  
 (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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month... 7 day... 10  
 year... 1948 hour... 7 minute... P. M.

21. I hereby certify that I attended the deceased from... May 18 to... July 10 1948  
 that I last saw her alive on... July 10 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death... Coronary occlusion  
 Duration... 10 minutes

Due to...  
 Due to...

Other conditions... diabetes mellitus 10 yrs  
 (Include pregnancy within 3 months of death)

Major findings:  
 Of operations...  
 Of autopsy... 61

PHYSICIAN  
 Underline the cause of 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?..... (Specify means of injury)  
 23. Signature... W. Harold Fowler (M. D. or other)  
 Address... Maysville, Mo. Date signed... 7-11-48

MOTHER FATHER

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

*W. E. Summersfield*

Licensed Embalmer No.....

*3007*

P. O. Address.....

*Stewartville*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

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

Registration District No. 99

Primary Registration District No. 4168

1. PLACE OF DEATH:

(a) County DeKalb  
(b) City or town Maryville  
(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 \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME Laura B. Delaney  
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 div  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_  
7. Birth date of deceased Sept 25 (Month) (Day) (Year)

8. AGE: Years 69 Months 9 Days 14 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation \_\_\_\_\_

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

MOTHER { 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_  
19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (Registrar's signature)

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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1948 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_  
and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Date signed \_\_\_\_\_

SUPPLEMENTARY

S-22689