No. 2
/47
7-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 18 1948

Registration District No. 12

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 32034

Primary Registration District No. 1000

Registrar's No. 1063

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Sisters Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 day (Specify whether years, months or days)
In this community: 30 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Kansas (b) County: Doniphan 999
(c) City or town: Elwood
(If outside city or town limits, write "RURAL")
(d) Street No.: Elwood, Kansas.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Oren T. Dailey
3. (b) If veteran, name war: No
3. (c) Social Security No.: None
4. Sex: Male
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name of husband or wife: Zina Dailey
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: December (Month) 12 (Day) 1884 (Year)

8. AGE: Years 63 Months 9 Days 22 If less than one day: hr. min.

9. Birthplace: Henry County (City, town, or county) Iowa (State or foreign country)
10. Usual occupation: Retired Car man
11. Industry or business: Grand Island R. R. Co.
MOTHER FATHER
12. Name: Matthew Dailey
13. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)
14. Maiden name: Jane
15. Birthplace: Unknown (City, town, or county) Unknown (State or foreign country)
16. (a) Informant: M. G. Dailey
(b) Address: Elwood, Kansas.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 10/6/48 (Month) (Day) (Year)
(c) Place: burial or cremation: Troy, Kansas.
18. (a) Signature of funeral director: Heaton-Burrman
(b) Address: St. Joseph, Mo.
19. (a) 10-9-48 (Date received local registrar) (b) G. C. Jenkins (Registrar's signature) 382

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: October day: 4 year: 1948 hour: 10 minute: 20 A.M.

21. I hereby certify that I attended the deceased from Oct 3, 1948 to Oct 4, 1948 that I last saw him alive on Oct 4, 1948 and that death occurred on the date and hour stated above.

Immediate cause of death: General Carcinosis — Duration: Unknown
Due to:
Due to:
Other conditions (Include pregnancy within 3 months of death):
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause of which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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: Ward Dyme M. D. M. D.
Address: 40 Corby Bldg. St. Joseph, Mo. Date signed: 10-5-48

Jefferson City Printing Co. (Licensed Embalmers, Statement on Reverse Side)

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 Danny O. Becker Registered Apprentice No. 247 working under my personal supervision.

Signed Eugene Wood

Licensed Embalmer No. 3804.

P. O. Address 319 So 10th St. Joseph, 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. X nov

Registration District No. 42 Primary Registration District No. 1000 Registrar's No. 1063

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: (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: Ben J. Dailey
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex: M
5. Color or race: W
6. (a) Single, widowed, married, divorced: Mrd
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive
7. Birth date of deceased: Dec (Month) 12 (Day) 1882 (Year)
8. AGE: Years 63 Months 9 Days If less than one day hr. min.
9. Birthplace (City, town, or county) Iowa (State or foreign country)
10. Usual occupation
11. Industry or business
FATHER 12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day year 1945 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.

	Duration
Immediate cause of death	
Due to Recto-peritoneal tumor (malignant)	
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

SUPPLEMENTARY

S-32034