

No. 2
1/47
17-39

Primary Registration District No. 5510

1. PLACE OF DEATH:

(a) County Henry
(b) City or town Bronnington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: RURAL FAIRVIEW TWP
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Life (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Henry 43
(c) City or town Bronnington
(If outside city or town limits, write "RURAL")
(d) Street No. Fairview Twp
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Emma M Hanahan
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 single
6. (b) Name of husband or wife - 6. (c) Age of husband or wife if alive - years
7. Birth date of deceased 1 21 1947
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
1 2 2 hr. min.

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

10. Usual occupation INFANT

11. Industry or business -
12. Name Leslie Hanahan
13. Birthplace Bronnington Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hayes
15. Birthplace Marysville Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Leslie Hanahan
(b) Address Bronnington Mo

17. (a) Burial (b) Date thereof 3-24-48
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Bronnington Cem

18. (a) Signature of funeral director Sickman & Quinn
(b) Address Clinton Mo

19. (a) 3-24-48 (b) R. H. Kenney
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23
year 1948 hour 2 minute 15 P.M.

21. I hereby certify that I attended the deceased from 1 to 19
that I last saw Dead on Arrival on 3-23-48
and that death occurred on the date and hour stated above.

Immediate cause of death Malnutrition
Due to 1 year

Due to

Other conditions (Include pregnancy within 3 months of death)

PHYSICIAN
Major findings: poor
Of operations
Of autopsy

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? 3
Signature Dr. P. S. Hallgren (A Means of injury)
Address Clinton Mo Date signed 3/24/48

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

MOTHER FATHER

RECEIVED

District Health Officer No. 7,

District File Number 2-48-319

Date Filed 3-29-48

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.....

not embalmed..... Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.