

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

33371

1. PLACE OF DEATH
 County Dwight Registration District No. 258
 Township Washington Primary Registration District No. 0360A
 City..... (No.....) St..... Ward.....

File No.....
 Registered No. 6 St..... Ward.....

2. FULL NAME James H Dalby
 (a) Residence No..... Ward.....
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Anna Dalby

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 8-1872

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
57 * 1 21

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Dwight Co Mo
 (STATE OR COUNTRY)

10. NAME OF FATHER Henry H Dalby

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Wisconsin

12. MAIDEN NAME OF MOTHER Mary Lee

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Birchman Co Mo

14. INFORMANT Mrs Anna Dalby
 (Address) Stewartville Mo

15. FILED Nov 19 1929 C M Davis REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Oct 29 19 29

17. I HEREBY CERTIFY, That I attended deceased from....., 19....., to....., 19..... that I last saw h..... alive on....., 19....., and that death occurred, on the date stated above, at about 6-P.M.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Stroke by lightning
striking Dalby
shattered the body any less 10/29
inquest (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 1929 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....

WAS THERE AN AUTOPSY? Yes

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed) J. M. F. Hester, M. D.
Nov 1 1929 (Address) Wichita Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Clarksdale Cemetery Nov 1 1929

20. UNDERTAKER ADDRESS
C M Davis - Clarksdale Mo

WHITE COPY; WITH UNFADING INK---THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

