

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

Do not use this space.

17,800 X

PLACE OF DEATH

County Marion
Township Marion
City Oakwood No. 1714

Registration District No. 547
Primary Registration District No. 13979

File No. _____
Registered No. 118
St. 2nd Ward

2. FULL NAME

Delbert Carl Dauron

(a) Residence. No. 1714 - 35 St Oakwood 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 | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Male | White | Single

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

June 30 - 1924

7. AGE - YEARS MONTHS DAYS | IF LESS than 1 day, hrs. or min.

3 | 10 | 11 | _____

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

Child

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Amada Mo

10. NAME OF FATHER

Wm K Dauron

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

Lincoln Co Mo

12. MAIDEN NAME OF MOTHER

Bessie L Day

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

Lincoln Co Mo

14. INFORMANT (Address)

Wm K Dauron
Oakwood Mo

15. FILED

5/28 C E Stode

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 1928

17. I HEREBY CERTIFY That I attended deceased from Apr 28 1928 to May 30 1928 that I last saw him alive on Apr 20 1928, and that death occurred, on the date stated above, at 12:30 A M

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia

10%

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

at home

IF NOT AT PLACE OF DEATH:

0 DID AN OPERATION PRECEDE DEATH? DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

NO
absorption

(Signed) J. M. Moyer, M. D.
, 19 (Address) Hambard 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

Golia Mo

DATE OF BURIAL

5/2 1928

20. UNDERTAKER

Wm M. Smith

ADDRESS

Hambard

ACTUALLY. PHYSICIANS SHOULD BE CAREFULLY SUPPLIED. AGE SHOULD BE CAREFULLY SUPPLIED. CAUSE OF DEATH IN PLAIN TERMS, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS VERY IMPORTANT.

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Marion Registration District No. 547 File No.
 Township Primary Registration District No. 3027 Registered No. 118
 City Hannibal (No.) St. Ward)

2. FULL NAME Delbert Carl Dawson

(a) Residence. No. St. 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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED S (write the word)

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED

- (a) Trade, profession, or particular kind of work
- (b) General nature of industry, business, or establishment in which employed (or employer)
- (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT

(Address)

15. FILED

5/28/18 W. E. Stode REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 1 19 28

17. I HEREBY CERTIFY That I attended deceased from 19, 19, and that I last saw him alive on 19, and that death occurred, on the date stated above, at m.

THE CAUSE OF DEATH WAS AS FOLLOWS:

Pneumonia Lobar

CONTRIBUTORY (SECONDARY)

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....

(Signed)....., M. D.

, 19 (Address)

*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

19

20. UNDERTAKER

ADDRESS,

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

S-17800

KC