

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

Do not use this space.  
**6113**

**1. PLACE OF DEATH**  
 County..... Green ..... Registration District No. 316 ..... File No. ....  
 Township..... Barn ..... Primary Registration District No. 5435 ..... Registered No. 4 .....  
 City..... No. .... St. .... Ward)

**2. FULL NAME** Albert Delday  
 (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** single  
 (write the word)  
**5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF**

**6. DATE OF BIRTH (MONTH, DAY AND YEAR)** May 16-1907

**7. AGE** YEARS MONTHS DAYS | If LESS than 1 day, hrs. or min.  
21 | 8 | 17

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

**9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)** Exciton Mo.

**10. NAME OF FATHER** Wm A. Delday

**11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)** Lawrence Co. Mo

**12. MAIDEN NAME OF MOTHER** Hattie M. Gilbre

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

**14. INFORMANT (Address)** Wm. Pellett Ash Grove Mo

**15. FILED** 7/10 1929 Dr Charles H. Over REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

**16. DATE OF DEATH (MONTH, DAY AND YEAR)** Feb-3 1929  
**17. I HEREBY CERTIFY, That I attended deceased from** Sept 1928, to Feb 1929, that I last saw him alive on Dec 11, 1928, and that death occurred, on the date stated above, at 11:50 a. m.

**THE CAUSE OF DEATH\* WAS AS FOLLOWS:**  
Pulmonary Tuberculosis  
33A  
about (duration) 1 yrs. .... mos. .... ds.

**CONTRIBUTORY (SECONDARY)** SI (duration) yrs. .... mos. .... ds.

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

**19. DID AN OPERATION PRECEDE DEATH?** no DATE OF .....

**20. WAS THERE AN AUTOPSY?** no

**WHAT TEST CONFIRMED DIAGNOSIS?** Clinical  
 (Signed) Charles H. McHaffee, M. D.  
2-6-1929 (Address) Ash Grove 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** Sinking Creek, Adair Co Mo | **DATE OF BURIAL** 2-4 1929

**20. UNDERTAKER** Galbraith | **ADDRESS** Ash Grove

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. MAR 22 1929

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