

JUN 24 1930

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

Do not use this space.

15529

1. PLACE OF DEATH

County Cape Girardeau Registration District No. 125
Township " Primary Registration District No. 3009
City " Loring Mill St. _____ Ward _____

File No. _____
Registered No. 408

2. FULL NAME Avery W. Dellinger

(a) Residence, No. Cape Rock add. 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 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Mar 13 - 1894

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
36 2 11

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)
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Bollinger Co.

10. NAME OF FATHER Ray Dellinger

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

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Don't know

14. INFORMANT Mrs S. D. Jarr
(Address) Cape Girardeau Mo.

15. FILED 7/26/30 W. K. Kuepper REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 24 1930

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 _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Accidental death
Left arm and left leg
amputated by Eibele Harv
JOSE (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 205 M 187 (duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Sherman Haugh, Coroner, D.

. 19 (Address) Jackson 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

Fairmount Cem. May 26 1930

20. UNDERTAKER ADDRESS

Walther Und. Co. Cape Gir., Mo.

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.

RECORD

