

JAN 22 1940

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

Do not use this space.

43240

1. PLACE OF DEATH

County *De Kalb*

Township *Washington*

City *Clarksdale*

Registration District No. *258*

Primary Registration District No. *5360*

File No. _____

Registered No. *2*

St. _____

Ward _____

2. FULL NAME *Ervin Robert Dalby*

(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 *male*

4. COLOR OR RACE *white*

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *single*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *1-9-33*

7. AGE

YEARS *6*

MONTHS *7*

DAYS *13*

If LESS than 1 day, _____ hrs. or _____ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Clarksdale De Kalb Miss*

FATHER

13. NAME *Ervin Dalby*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *King City Miss*

MOTHER

15. MAIDEN NAME *Hazel Jones*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Madison Kansas*

17. INFORMANT (ADDRESS) *Ervin Dalby Clarksdale Miss*

18. BURIAL, CREMATION, OR REMOVAL

PLACE *Clarksdale* DATE *8-23 1939*

19. UNDERTAKER (ADDRESS) *John Brown Clarksdale Miss*

20. FILED *Jan 19 1940 Mrs C.H. Davis Registrar*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *8-22-1939*

22. I HEREBY CERTIFY, That I attended deceased from *8/22 1939, to 8-22-39*, 19*39*

I last saw ~~him~~ alive on *8/22*, 19*39*. Death is said to have occurred on the date stated above, at *8 P.m.*

The principal cause of death and related causes of importance were as follows:

Cholera Morbus

Meningeal involvement

Other contributory causes of importance: *127*

Lack Proper Nourishment

Name of operation _____ Date of _____

What test confirmed diagnosis? *Clinical* Was there an autopsy? *No*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify _____

(Signed) *O. L. Perkins*, M. D.

(Address) *Clarksdale, Miss*

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.

RECEIVED

District Health Officer No. 11

District File Number 140-2000

Date Filed JAN 20 1940