

STANDARD CERTIFICATE OF DEATH

State File No. 23131Registration District No. 749Primary Registration District No. 6225Registrar's No. 9

1. PLACE OF DEATH

- (a) County Wright
 (b) City or town Grove Springs
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

- (d) Length of stay: In hospital or institution
- 2

In this community all his life (Specify whether years, months or days)3. (a) PRINT FULL NAME William Dawson Delt

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married6. (b) Name of husband or wife Missouri L. Delt 6. (c) Age of husband or wife if alive 57 years7. Birth date of deceased April 5 1862
(Month) (Day) (Year)8. AGE: Years 72 Months 1 Days 28 If less than one day hr. _____ min. _____9. Birthplace Wright Co. Mo
(City, town, or county) (State or foreign country)10. Usual occupation Farming

11. Industry or business _____

12. Name Jacob Delt 913. Birthplace Jenn (State or foreign country)14. Maiden name Elizabeth Randolph15. Birthplace West Union (State or foreign country)16. (a) Informant's own signature Missouri L. Delt(b) Address Grove Springs, Mo17. (a) Burial (b) Date thereof 6/4/40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Shady18. (a) Signature of funeral director W. F. Schmitt(b) Address Lebanon Mo19. (a) 6-1040 (b) C. J. Howell
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Wright(c) City or town Grove Springs
(If outside city or town limits, write "RURAL.")(d) Street No. Rural
(If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 3
year 1940 hour 3 minute 25 P. M.21. I hereby certify that I attended the deceased from March
March - 1, 1940 to June 2, 1940
that I last saw him alive on June 2, 1940
and that death occurred on the date and hour stated above.Immediate cause of death Chronic Interstitial Nephritis
Duration _____

Due to _____

Due to Aortic Insufficiency

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: 121
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

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While at work _____ (Specify type of place) (e) Means of injury _____23. Signature W. F. Schmitt (M. D. or other) _____Address Lebanon Mo Date signed 6/4/40W. F. Schmitt

(Licensed Embalmer's Statement on Reverse Side)

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. 61

District File Number 744-2375

Date Filed JUL 12 1940

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by #107

Myself, Registered Apprentice No. _____
working under my personal supervision.

Signed W. E. Holman

Licensed Embalmer No. 4107

P. O. Address Lebanon Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.