

S. No. 2  
4-5-42  
5-17-39  
I X325.4

38953

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED NOV 17 1944

Registration District No. 333

Primary Registration District No. 3074

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Scott  
(b) City or town Sikeston Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: X  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community About Two Weeks years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Colorado (b) County Denver 999  
(c) City or town Denver 5  
(If outside city or town limits, write "RURAL") 0  
(d) Street No. 4552 Meade St.  
(If rural, give location)  
(e) Citizen of foreign country? No. (Yes or-No)  
If yes, name country 2

3. (a) PRINT FULL NAME Henry Ashmore DeLay

3. (b) If veteran, name war X 3. (c) Social Security No. 521-10-5530

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Edna DeLay 6. (c) Age of husband or wife if alive 60 years  
7. Birth date of deceased 11 25 1873  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 8 If less than one day  
.....hr. ....min.

9. Birthplace Oran Mo. 0  
(City, town, or county) (State or foreign country)

10. Usual occupation.....

11. Industry or business.....

MOTHER FATHER { 12. Name Charley DeLay  
13. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)  
14. Maiden name Georgia Anna Ashmore  
15. Birthplace Unknown 9  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Edna DeLay  
(b) Address 4552 meade St. Denver, Colo.

17. (a) Burial (b) Date thereof 11/6/44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Morley Mo.  
18. (a) Signature of funeral director John Albritton  
(b) Address Sikeston Mo.

19. (a) 11/16/44 (b) Louis Largent  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 3  
year 1944 hour 3 minute 20 A. M.

21. I hereby certify that I attended the deceased from 11/3/44  
....., 19....., to 11/3/44 19.....;  
that I last saw him alive on 11/3/44 19.....;  
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris

Due to.....

Due to Do not know

Other conditions (Include pregnancy within 3 months of death)

Major findings:  
Of operations 94  
Of autopsy.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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?

While at work?..... (Specify type of place) (e) Means of injury 2

23. Signature M. C. Miller (M. D. or other) MD  
Address Sikeston Mo. Date signed 11/3/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1318

RECEIVED

District Health Office No. 2,

District File Number 1144-1850

Date Filed 11-15-44

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.....

.....Embalmed....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*John Allerton*

Licensed Embalmer No. 2941

P. O. Address Sikeston 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, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. Dec

Registration District No. 323

Primary Registration District No. 3074

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:  
 (a) County Scott  
 (b) City or town Sikeston  
(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 \_\_\_\_\_  
(Specify whether  
 In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Henry A. DeLay  
 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 M  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased Nov. 21 (Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace Illinois (City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business do not from business

MOTHER FATHER {  
 12. Name \_\_\_\_\_  
 13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)  
 14. Maiden name \_\_\_\_\_ (State or foreign country)  
 15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country)

16. (a) Informant \_\_\_\_\_  
 (b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
 (c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
 (d) Street No. \_\_\_\_\_  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
 year 1944 minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_  
 that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_  
 Major findings: 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?  
 While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature \_\_\_\_\_ (M. D. or other)  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

38953