

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

30913

State File No.

No. 300

10.48

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

BIRTH NO. _____		REG. DIST. NO. <u>172</u>		PRIMARY REG. DIST. NO. <u>5642</u>		Registrar's No. <u>71</u>	
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Middleton Township</u>			c. LENGTH OF STAY (in this place)	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Middleton Township</u>			58
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Home</u>				d. STREET ADDRESS (If rural, give location) <u>3 miles Southwest of Waverly, Mo.</u>			
3. NAME OF DECEASED (Type or Print)		a. (First) <u>Arthur</u>		b. (Middle) <u>Herbert</u>		c. (Last) <u>Delichs</u>	
4. DATE OF DEATH		(Month) <u>Sept.</u>		(Day) <u>9</u>		(Year) <u>49</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>July 24, 1901</u>		9. AGE (In years last birthday) <u>48</u> IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Fred Delichs</u>		13b. MOTHER'S MAIDEN NAME <u>Katherine Heimsoth</u>		14. NAME OF HUSBAND OR WIFE <u>Frieda Delichs</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Freda Delichs</u> ADDRESS <u>Waverly</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Coronary Occlusion, Acute</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Pulmonary infarct</u>		DUE TO (c)		<u>21 days</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture Rt. knee with dislocation</u>						<u>39 days</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>accident</u>		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Farm</u>		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Middleton 54 Lafayette Mo.</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>July 29 49 11:30 P.M.</u>		21e. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>1000 lbs. steel fell onto knee</u>			
22. I hereby certify that I attended the deceased from <u>29 July, 1949</u> to <u>9 Sept., 1949</u> , that I last saw the deceased alive on <u>9 Sept., 1949</u> and that death occurred at <u>7:35 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Douglass Kelling, M.D.</u>				23b. ADDRESS <u>Waverly, Missouri</u>		23c. DATE SIGNED <u>9-9-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Sept 15, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Cole Camp, Missouri</u>	
DATE REC'D BY LOCAL REG. <u>9-12-1949</u>		REGISTRAR'S SIGNATURE <u>Chas. H. Landrum</u>		154		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Gray</u> ADDRESS <u>Cole Camp, Mo.</u>	

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED SEP 20

District Health Officer No. 8,

District File Number _____

Date Filed 9-30-49

OCT 3 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Signed _____

Harold J. Perry

Signed _____
Student Embalmer

Licensed Embalmer No. 4097

P. O. Address Cole Camp, 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.