

FILED JAN 20 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **884**

BIRTH NO. _____ REG. DIST. NO. **128** PRIMARY REG. DIST. NO. **5463** Registrar's No. **14**

390

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

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) Strafford, Rural-Jackson		c. CITY (If outside corporate limits, write RURAL and give township) Strafford, Rural-Jackson Twp	
c. LENGTH OF STAY (in this place) 800 yrs		d. STREET ADDRESS (If rural, give location) Rt. 1 Strafford	
d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. 1 Strafford			

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Delp c. (Last) Delp			4. DATE OF DEATH (Month) (Day) (Year) March 6 1950			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 28 1875	9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Jacob Delp		13b. MOTHER'S MAIDEN NAME Mary Westner		14. NAME OF HUSBAND OR WIFE Dona Delp	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. No		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Mrs. Dona Delp Strafford	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Disease					3
ANTECEDENT CAUSES		DUE TO (b) Arterial Sclerosis			3
* This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			4 201
II. OTHER SIGNIFICANT CONDITIONS		Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION No		19b. MAJOR FINDINGS OF OPERATION No		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) No		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) No	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) No		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? No	

22. I hereby certify that I attended the deceased from **1/3, 1950**, to **1/6, 1950**, that I last saw the deceased alive on **1/6, 1950**, and that death occurred at **8:20p m.**, from the causes and on the date stated above.

23a. SIGNATURE (Print or Type) R. H. Froeh		23b. ADDRESS Strafford Mo.		23c. DATE SIGNED 1/9/50	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 1-8-50		24c. NAME OF CEMETERY OR CREMATORY Azelwood Cemetery		24d. LOCATION (City, town, or county) (State) Springfield Mo.	
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DATE REC'D BY LOCAL REG. 1-10-50		REGISTRAR'S SIGNATURE W.S. Handley MD		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. W. Klingner & Co. Springfield	
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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.

Student
Student Embalmer

Signed *C. J. Lane Jr.*

Licensed Embalmer No. 4176

P. O. Address Springfield

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.