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

Do not use this space.

Dr Denney

File No. 4642

Registered No. 112

1. PLACE OF DEATH

County: Greene — Registration District No. 318

Township: — Primary Registration District No. 2004

City: ... (No. ... St. ... Ward) St. Johns Hosp.

2. FULL NAME: Delos L. Brady

(a) Residence. No. Nathans St. 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: M

4. COLOR OR RACE: W

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~ (write the word): W. L. Brady

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Mar 27-1880

7. AGE: Years 49 | Months 2 | Days 7 | If LESS than 1 day, ... hrs. or ... min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Douglas Co Missouri

PARENTS

10. NAME OF FATHER: William Hardison

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY): Mo

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY):

14. INFORMANT: W. L. Brady (Address) Nathans Mo.

15. FILED 2-6, 1930 Lon Sharp REGISTRAR

3 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): Feb 4th 1930

17. I HEREBY CERTIFY, That I attended deceased from Feb 3, 1930, to Feb 4, 1930, that I last saw h. alive on Feb 4, 1930, and that death occurred, on the date stated above, at 8 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Intestinal Obstruction due to strangulated Femoral Hernia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (SECONDARY)

(duration) ... yrs. ... mos. ... ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? Yes DATE OF Feb 4. 30

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Operation

(Signed) James E. Drury, M. D.

2-6, 1930 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Nathans Mo. | DATE OF BURIAL: 2/6 1930

20. UNDERTAKER: T. M. Lohmeyer | ADDRESS: Springfield

735 S Main

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH.
County: Greene — Registration District No.: 318 — File No.:
Township: — Primary Registration District No.: 2001 — Registered No.: 112
City: Springfield — No.: — St.: — Ward:

2. FULL NAME: Delia Brady

(a) Residence. No. (Usual place of abode) St., Ward (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: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): M

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE — YEARS — MONTHS — DAYS — If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Unknown
(STATE OR COUNTRY): Unknown

14. INFORMANT
(Address)

15. FILED 2/6, 19 30 — Lou Sharp, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 4 1930

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at ....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (SECONDARY)
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL 19

20. UNDERTAKER — ADDRESS

SUPPLEMENTARY

S 4642