

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

Do not use this space.

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1932
7
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1. PLACE OF DEATH

County Ray
Township Knoxville
City _____ (No. _____)

Registration District No. 915
Primary Registration District No. 6236

File No. _____
Registered No. 11
St. _____ Ward _____

2. FULL NAME

Delilah J Green

(a) Residence, No. _____ 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widow

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Aug 10 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
73 3 19

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ray County Missouri

13. NAME Patterson Albright

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

15. MAIDEN NAME Wilson

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) North Carolina

17. INFORMANT Chas Green
(ADDRESS) Sumner, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Bethel Camp Dec 13 1932

19. UNDERTAKER Alphonse & Cooley
(ADDRESS) P. O. Box 200

20. FILED Dec 16 1932 Mrs. G.W. Garner
Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-10, 1932

22. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1932, to 12-10, 1932

I last saw her alive on 12-10, 1932. Death is said to have occurred on the date stated above, at 2 P. m.

The principal cause of death and related causes of importance were as follows:

Auricular Fibrillation
9511
9511
Date of onset Aug 1932

Other contributory causes of importance: ①

Name of operation none Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify _____

(Signed) Chas Wilson, M. D.
(Address) Polo Mo

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.

WHITE PRINT, WITH OUTFRONT IMPRESSION—THIS IS A PERMANENT RECORD

