

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

Do not use this space.

8103

1. PLACE OF DEATH

County Jackson Registration District No. 399
 Township Raw Primary Registration District No. 1002
 City Kansas City (No. 3423 Prospect) St. _____ Ward _____

File No. _____
 Registered No. 955

2. FULL NAME James Alexander Day

(a) Residence No. 3423 Prospect 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 14 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
67 | 8 | 20

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

9. BIRTHPLACE (CITY OR TOWN) New Orleans
 (STATE OR COUNTRY) La.

10. NAME OF FATHER Samuel J. Day

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
 (STATE OR COUNTRY) England

12. MAIDEN NAME OF MOTHER Mary McCollough

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

14. INFORMANT Charlotte M. Day
 (Address) 3423 Prospect

15. FILED 3/6 19 27 M. M. Grove REGISTRAR
Ass.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 4 19 27

17. I HEREBY CERTIFY, That I attended deceased from 17 January, 1926, to March 4, 1927, that I last saw him alive on March 4, 1927, and that death occurred, on the date stated above, at 8:27 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic Interstitial nephritis
131
9:21/270 (duration) 2 yrs. _____ mos. _____ ds.

CONTRIBUTORY Cardiac Insufficiency
 (SECONDARY) (duration) _____ yrs. _____ mos. 6 ds.

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

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS Physical signs & analysis
 (Signed) Burroleg's Agin M. D.
3/5, 1927 (Address) 3438 Prospect Ave.

*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 Mt. Moriah DATE OF BURIAL 3/6 19 27

20. UNDERTAKER Caylor Bros ADDRESS 1800 Linwood

Dr. Payne
Birmingham

0482 Div. 3438 Prefect

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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township W. City
City W. City (No.)

Registration District No. 399
Primary Registration District No. 1002

File No.
Registered No. 953-
St. Ward)

2. FULL NAME

(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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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) June 14 - 1858

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 8 20

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)

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT (Address)

15. FILED 3/6 27 M. M. Brown REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar 4 - 1927

17. I HEREBY CERTIFY That I attended deceased from 18..... to 19..... (that I last saw him alive on 18....., and that death occurred, on the date stated above, at..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

CONTRIBUTORY (SECONDARY)

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. (See reverse side for additional space.)

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

20. UNDERTAKER ADDRESS

RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-8102