

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

Do not use this space.

30879

1. PLACE OF DEATH

County.....Jefferson
Township.....Joachim
City.....Crystal City

Registration District No. 421
Primary Registration District No. 5575

File No. _____
Registered No. 89
St. _____ Ward _____

2. FULL NAME Clarence Edward Day

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)
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.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Infant

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 26, 1928

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

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

9. BIRTHPLACE (CITY OR TOWN) Crystal City Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER Edward Day

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

12. MAIDEN NAME OF MOTHER Anna Marler

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

14. INFORMANT Anna LaRosa
(Address) Crystal City Mo

15. FILED 9/5/28 IS J. E. Rutledge REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-27 1928

17. I HEREBY CERTIFY, That I attended deceased from 9-20, 1928, to 9-27, 1928, that I last saw him alive on 9-27, 1928, and that death occurred, on the date stated above, at 9 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

malnutrition
100 / 60 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) _____ (duration) yrs. mos. da.

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

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

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) SK Vailup M.D. M. D.
, 19 (Address) Crystal City Mo

*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 Festus Mo DATE OF BURIAL Sept 27 1928

20. UNDERTAKER Quester & Vineyard ADDRESS Festus 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.

2 1928

CONTINUING INFORMATION IS A PERMANENT RECORD

