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

REC'D JUN 15 1939

19486

1. PLACE OF DEATH
County Phelps — Registration District No. 677 — File No.
Township — Primary Registration District No. 4403 — Registered No. 52
City Rolla (No. ..... St. ..... Ward)

2. FULL NAME Henry W. Day
(a) Residence. No. Rolla Route 1 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: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 1, 1864

7. AGE: Years 74 — Months 9 — Days 9 — If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS
10. NAME OF FATHER Samuel Day
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Dont
(STATE OR COUNTRY) Know
12. MAIDEN NAME OF MOTHER Nancy Stogsdill
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dont
(STATE OR COUNTRY) Know

14. INFORMANT Frank Day
(Address) Rolla Mo

15. FILED May 12 1939 Jos F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 10 1939

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1939, to May 10, 1939 that I last saw him alive on May 10, 1939, and that death occurred, on the date stated above, at 11:00 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cerebral Hemorrhage

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

CONTRIBUTORY (SECONDARY) Senility

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

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? no DATE OF
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) E. E. Feind, M. D
, 19 (Address) Box 534 Rolla, 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: Wishon — DATE OF BURIAL: May 12 1939

20. UNDERTAKER: Nuell Olson — ADDRESS: Rolla Mo

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

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Township..... Primary Registration District No..... Registered No. .....

City..... (No.....; .....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. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

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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.

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(STATE OR COUNTRY)

PARENTS

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....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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

CONTRIBUTORY.....
(SECONDARY)
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