

REC'D SEP 15 1939

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

30044
Do not use this space.

1. PLACE OF DEATH

(a) County Papley Registration District No. 759
(b) Township Jordan Primary Registration District No. 3989 Registered No. 1620
(c) City _____ (d) Street No. _____ St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 000 Sarah Jane Day St. 11
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widowed
6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Frank Day
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 6-21-1866
7. AGE YEARS 73 MONTHS 4 DAYS 25 If LESS than 1 day, _____ hrs. or _____ min.

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. Housewife
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) Iowa 1

13. NAME John Rowan 1

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Penn. 1

15. MAIDEN NAME _____

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) unknown

17. INFORMANT Mr. Rowan Day - son (ADDRESS) Route 2

18. BURIAL, CREMATION, OR REMOVAL PLACE Good Hope Cem. DATE 8-17-39 19

19. FUNERAL DIRECTOR (NAME) Jordan (ADDRESS) Route 2

20. FILED 8-17-39 Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-16-39 19
22. I HEREBY CERTIFY, That I attended deceased from June 24, 1939, to August 16, 1939
I last saw her alive on July 25, 1939. Death is said to have occurred on the date stated above, at 1:15 p.m.
The principal cause of death and related causes of importance were as follows:

Cancer of stomach and Colon

Other contributory causes of importance:

Emaciation

Name of operation none Date of _____
What test confirmed diagnosis? Clinical Was there an autopsy? _____

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? _____
If so, specify _____

(Signed) J. J. Williams, M. D.
1714 (Address) Womplem. Mo.

46

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

District File Number 939155

Date Filed 9589

Signed

J. G. Jordan

Licensed Embalmer No. 320

P. O. Address Donipha

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

30044
Do not use this space.

1. PLACE OF DEATH

(a) County Repley Registration District No. 750
 (b) Township Jordan Primary Registration District No. 5987
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. 11 How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Sarah Jane Day

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Wid

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,hra. ormin.
73 1 25

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

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

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-16 1939

22. I HEREBY CERTIFY, That I attended deceased from _____ 1939 to _____ 1939

I last saw h. _____ alive on _____ 1939. Death is said

to have occurred on the date stated above, at _____ m.

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

Cancer of stomach and colon
Colon
Colon
 Other contributory causes of importance:
Transition
H6

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____ 1939

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? _____

If so, specify _____

(Signed) J. E. Williams, M. D.

(Address) Doniphan

N. B. - 905
 CAUSE
 REGISTRATION
 information should be carefully checked and verified before registration. If any error is found, it may be corrected before registration is completed. If any error is found after registration is completed, it may be corrected only by a court of law.
 STATE OF MISSOURI
 DEPARTMENT OF HEALTH
 BUREAU OF VITAL STATISTICS
 REGISTRATION
 INFORMATION SHOULD BE CAREFULLY CHECKED AND VERIFIED BEFORE REGISTRATION. IF ANY ERROR IS FOUND, IT MAY BE CORRECTED BEFORE REGISTRATION IS COMPLETED. IF ANY ERROR IS FOUND AFTER REGISTRATION IS COMPLETED, IT MAY BE CORRECTED ONLY BY A COURT OF LAW.

SUPPLEMENTARY

OF THE DISTRICT OF COLUMBIA
IN THE MATTER OF THE ESTATE OF