

OCT 14 1939 791
Registration District No.

Primary Registration District No.

1. PLACE OF DEATH: **1003**
(a) County _____
(b) City or town **St Louis Mo**
(c) Name of hospital or institution: **Missouri Baptist Hospital**
(d) Length of stay: In hospital or institution **7 days**
In this community **4 yrs**

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St Louis**
(d) Street No. **5886 Page**
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME **Robert O Day**
(b) If veteran name was **Unknown** (c) Social Security No. **Unknown**
4. Sex **Male** 5. Color or race **White**
6. (b) Name of husband or wife **Elizabeth** 6. (c) Age of husband or wife if alive **24** years
7. Birth date of deceased **Feb 17 1903**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **Sept** day **16** year **1939** hour **5:00** minute **A.**
21. I hereby certify that I attended the deceased from **Sept 15** 19**39**, to **Sept 16** 19**39**
that I last saw him alive on **Sept 16** 19**39**
and that death occurred on the date and hour stated above.
Immediate cause of death **Intestinal Obstruction** Duration **7 days**

8. AGE: Years **36** Months **6** Days **29** If less than one day _____ hr. _____ min.
9. Birthplace **Franklinton No Car 1**
10. Usual occupation **Salesman**
11. Industry or business _____

Due to **Post-operative - appendectomy 9/7/39**
Due to _____
Other conditions **Appendicitis, acute 9/7/39**
Major findings: **Of operations Appendix acute, appendectomy 9/7/39**
Of autopsy **None**

MOTHER FATHER
12. Name **Robert O Day**
13. Birthplace **North Carolina**
14. Maiden name **Unknown**
15. Birthplace **Unknown**
16. (a) Informant's own signature **Elizabeth O Day**
(b) Address **5886 Page**
17. (a) **Burial** (b) Date thereof **9-16-39**
(c) Place: burial or cremation **Cuba - Mo.**
18. (a) Signature of funeral director **E. E. Long**
(b) Address **Bourbon Mo**
19. (a) **SEP 20 1939** (b) **J. J. B. [Signature]**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work _____ (Specify type of place) (e) Means of injury _____
23. Signature **Island Shepper** (M. D. or other) _____
Address **4500 Olive** Date signed **9/19/39**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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.

PHYSICIAN
Underline the cause to which death should be charged statistically.

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.

Signed Howard P. Rowland
Licensed Embalmer No. 3114
P. O. Address St. Louis, Mo

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

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