

1939 OCT 19

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

33068
Do not use this space.

1. PLACE OF DEATH

(a) County New Madrid Registration District No. 603
 (b) Township Como Primary Registration District No. 4339
 (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

Donald Ray Day
 (a) Residence, No. St. 7
 (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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 2 - 1939

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|--------|----------|----------|----------|----------------------------------|
| | <u>0</u> | <u>0</u> | <u>0</u> | <u>2</u> |

OCCUPATION

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

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Parma mo

FATHER

13. NAME Becil M. Day

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

MOTHER

15. MAIDEN NAME Freda M. Sturgeon

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

17. INFORMANT (ADDRESS) Becil M. Day
Parma mo, R 2

18. BURIAL, CREMATION OR REMOVAL PLACE Stephens DATE 9-3-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Craig

20. FILED 9-3- 1939 Deborah Husted
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept. 2 1939

22. I HEREBY CERTIFY, THAT I attended deceased from Sept 2 1939 to Sept 2 1939
 I last saw him/her alive on 19..... Death is said to have occurred on the date stated above, at 9 P. m.
 The principal cause of death and related causes of importance were as follows:
Premature 7 months Defamed Hydrocephalus Club-foot. Cerebral Palsy.
 Date of onset

Other contributory causes of importance:

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 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) Deborah Husted M. D.
 (Address) Galma 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.

RECEIVED

District Health Officer No. 2,

District File Number 1039-286

Date Filed 10-16

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.....

Licensed Embalmer No.....

P. O. Address.....

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.