

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

Do not use this space.

FILED FEB 13 1940

4080

1. PLACE OF DEATH

County
Township
City

Texas 2
Chestnut 0
Bucara 1

Registration District No.
Primary Registration District No.

866
6146

File No.
Registered No.
St. Ward

2. FULL NAME

(a) Residence

(Usual place of abode)

John W. Day, 000
Dexall Rural

Ward

(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 W. 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Use the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (Last name of)

Gene Day

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

1-28-1860

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, hrs. or min.

79 11 25

OCCUPATION

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

Farmer

9. Industry or business in which work was done, as silk mill, 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)

Indiana

13. NAME

Unknown

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

Unknown

15. MAIDEN NAME

Unknown

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

Unknown

17. INFORMANT (ADDRESS)

James Stewart

18. BURIAL, CREMATION, OR REMOVAL

PLACE

Riley Cem DATE 1-24 1940

19. UNDERTAKER (ADDRESS)

XOXOX

20. FILED

1-30 1940

Maggie Murphy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-23 1940

22. I HEREBY CERTIFY, That I attended deceased from

I last saw ~~the~~ ^{deceased} alive on ~~1-23-1940~~ ^{without need of therapy}

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

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

Sudden death, from heart attack, 2

Other contributory causes of importance:

95 1/2

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)

Dr. J. M. Reed, M.D.
Summersville

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. 5,

District File Number 240184

Date Filed 2240