V. S. No. 2
M—11-10-39
ev. 5-17-39
I X21492

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

FILED APR 2 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1003

State File No. 8842

Registration District No. 791

Primary Registration District No.

Registrar's No. 2325

1. PLACE OF DEATH:

(a) County

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Missouri Baptist Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)

In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

(c) City or town St. Louis 22
(If outside city or town limits, write "RURAL")

(d) Street No. 1212 So. 9th St.
(If rural, give location)

(e) If foreign born, how long in U. S. A. years

3. (a) PRINT FULL NAME Mary Day

3. (b) If veteran, name war

3. (c) Social Security No. none

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Frank Day

6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased March (Month) 4 (Day) 1878 (Year)

8. AGE: Years 62 | Months 0 | Days 3 | If less than one day hr. min.

9. Birthplace (City, town, or county) Italy (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Unk Anato
13. Birthplace (City, town, or county) Italy (State or foreign country)

MOTHER
14. Maiden name Unk Unk
15. Birthplace (City, town, or county) Italy (State or foreign country)

16. (a) Informant Frank Day
(b) Address 1212 So. 9th St.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3/11/40 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director E. J. Schnur
(b) Address E. J. Schnur 3125 Lafayette

19. (a) MAR 9 1940 (Date received by local registrar) (b) [illegible] (Signature of registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 7 year 1940 hour 10:15 minute P M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Primary Adenocarcinoma of Hard Palate Metastasis in Lymph Glands.

Due to Lymph Metastasis

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations H6

Of autopsy

Duration

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

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? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed 3-9-40

(Licensed Embalmer's Statement on Reverse Side)

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 Jos B Wollmer

Licensed Embalmer No. 4014

P. O. Address 3125 Lafayette ave

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.