

SEP 23 1940

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29378

Registration District No. 686

Primary Registration District No. 2914

Registrar's No. 8

1. PLACE OF DEATH:

(a) County Pike
 (b) City or town Indian Point
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 2
 (Specify whether
 In this community
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Pike
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME

Catherine E. Day3. (b) If veteran,
name war3. (c) Social Security
No.

4. Sex F 5. Color or race W 6. (a) Single, widowed, married,
divorced Widowed
 6. (b) Name of husband or wife Chas Day 6. (c) Age of husband or wife if
alive _____ years
 7. Birth date of deceased Oct 21 1886
 (Month) (Day) (Year)

8. AGE: Years 84 Months 1 Days 25 If less than one day
 hr. _____ min. _____

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

10. Usual occupation Housekeeping

11. Industry or business

MOTHER FATHER { 12. Name Assie Fay
 13. Birthplace Boonville / Missouri
 (City, town, or county) (State or foreign country)
 14. Maiden name Assie Fay
 15. Birthplace Boonville / Missouri
 (City, town, or county) (State or foreign country)

16. (a) Informant Walter Day(b) Address Wendelin St17. (a) Burial (b) Date thereof Aug 9
 (Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Wendelin St18. (a) Signature of funeral director W. H. Blaud(b) Address Wendelin St19. (a) Aug 9 1940 (b) Gene Bentz
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 6
 year 1940 hour 5 AM minute _____ M.

21. I hereby certify that I attended the deceased from Aug - 1935
Aug 6 1935 to Aug 6 1940
 that I last saw her alive on May 16 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer on face & neck Duration 5 yrs

Due to _____

Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____

Of autopsy _____

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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 W. H. Blaud (M. D. or other) MDAddress Wendelin St Date signed 8/9/40

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RECEIVED

District Health Officer No. 10

District File Number 9-40-1738

Date Filed SEP 10 1940

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 W B Waters

Licensed Embalmer No. 3325

P. O. Address Wardline

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, fact should be so stated above.

Registration District No. **686**

Primary Registration District No. **5914**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Polk**
(b) City or town **Indian Twp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Catherine E. Day

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **7** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**
6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years
7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years **84** Months **1** Days **23** If less than one day _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) _____ (State or foreign country) _____

14. Maiden name _____

15. Birthplace (City, town, or county) _____ (State or foreign country) _____

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **6** year **1940** hour _____ minute _____ M.

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

Immediate cause of death: **Asphyxiation on face and neck. Right side of nose & extending down right cheek.**

Other conditions (Include pregnancy within 3 months of death) **52**

Major findings: Of operations _____

Of autopsy _____

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? _____
While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature **H. H. Blair** (M. D. or other) _____
Address **Wardenship** Date signed _____

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

SUPPLEMENTAL

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

