

8 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

41186

State File No.

4579

Registration District No. 399

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
5814 Quincy
(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 10 yrs
years, months or days)

3. (a) PRINT FULL NAME Joseph J. Day

8. (b) If veteran, name war No 3. (c) Social Security No. No

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Ethel Day 6. (c) Age of husband or wife if alive unobtainable years

7. Birth date of deceased Aug. 4 1898
(Month) (Day) (Year)

8. AGE: Years 42 Months 3 Days 26 If less than one day hr. min.

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

10. Usual occupation Truck Driver

11. Industry or business self

12. Name Nathaniel Day

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

14. Maiden name Carrie Brown

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

16. (a) Informant Ethel Day

(b) Address 5814 Quincy 12-2-40

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-2-40
(Month) (Day) (Year)

(c) Place: burial or cremation Spring Hill Kansas

18. (a) Signature of funeral director Mrs. C.L. Forster

(b) Address 918 Brooklyn

19. (a) 12-2-40 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits write "RURAL")
(d) Street No. 5814 Quincy
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 30
year 1940 hour 7 minute 35 A. M.

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

Legionnaires
Pulmonary hemorrhage
Septic disease of the lungs
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy Yes

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? _____

3/0 While at work _____ (Specify type of place) (e) Means of injury _____

23. Signature [Signature] (M. D. or other)

Address K.C. Mo Date signed _____

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

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 Me

....., Registered Apprentice No.
working under my personal supervision.

Signed

E. H. Wain

Licensed Embalmer No. 2570

P. O. Address H. E. 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.