S. No. 2
—11-10-39
5-17-39
P I X21492

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

FILED JUL 14 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22826

Registration District No. 796 Primary Registration District No. 3038 Registrar's No. 102

1. PLACE OF DEATH:
(a) County: Saline
(b) City or town: Marshall
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 602 E. Mitchell
(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: 35 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Saline 97
(c) City or town: Marshall 1
(If outside city or town limits write "RURAL")
(d) Street No.: 602 E. Mitchell 2
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: OSCAR MARION DAY
3. (b) If veteran, name war: ____ 3. (c) Social Security No.: ____
4. Sex: M 5. Color or race: W 6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Ollie Day 6. (c) Age of husband or wife if alive: 58 years
7. Birth date of deceased: Dec (Month) - 11 (Day) - 1875 (Year)

8. AGE: Years	Months	Days	If less than one day
65	6	8	____ hr. ____ min.

9. Birthplace: Harrison Co (City, town, or county) Ohio (State or foreign country)
10. Usual occupation: Laborer
11. Industry or business: ____
FATHER 12. Name: Squire Garner Day
13. Birthplace: / Ill (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name: Alpha Reed
15. Birthplace: / Ill (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs Ollie Day
(b) Address: Marshall Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 6-22-1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Olive Cem. Saline Co
18. (a) Signature of funeral director: Harry Hershberger
(b) Address: Marshall Mo
19. (a) 6-21-41 (Date received local registrar) (b) Dep. Mary Kent (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19-1941 year ____ hour 6 minute 30 A. M.
21. I hereby certify that I attended the deceased from June 8-41, 19__ to June 19, 1941; that I last saw him alive on June 19, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myocardial failure	
Due to: Hypertension	
Due to: Arteriosclerosis	
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 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: John R. Lawrence (M. D. or Coroner) O
Address: Marshall, Mo Date signed: June 21-41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 7-10-41
Date Filed

MAR 28 1951

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 [signature]

Licensed Embalmer No. 2478

P. O. Address Clinton Ill

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.

No. 2
-13-40
17-39
X23159

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22826

Registration District No. 196 Primary Registration District No. 3038 Registrar's No. 102

1. PLACE OF DEATH:
(a) County Saline
(b) City or town Marshall
(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 years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Saline
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 602 E Mitchell
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Oscar Marion Day
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced M
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 Months Days If less than one day: hours min.
9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 19 year 194[illegible] 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 — Duration
Myocardial failure
Due to Chronic myocarditis
Due to Hypertension
Due to arteriosclerosis

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 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?
While at work? (Specify type of place) (e) Means of injury
23. Signature (M. D. or other)
Address Date signed

(Licensed Embalmer's Statement on Reverse Side)

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

Marshall Mo.

SUPPLEMENTAL

93 F

S-22826

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 w the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.