

**FILED JAN 20 1943**  
Registration District No. **24382**

Primary Registration District No. **6263**

002

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

**1. PLACE OF DEATH:**  
 (a) County **GREENE Webster**  
 (b) City or town **Waycross R 4**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: **Finley Ave**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **1** (Specify whether)  
 In this community **9 months** (years, months or days)

**3. (a) PRINT FULL NAME** **MADISON S. A DAY**  
 3. (b) If veteran, name war   
 3. (c) Social Security No.

4. Sex **M O** 5. Color or race **white**  
 6. (a) Single, widowed, married, divorced **Married**  
 6. (b) Name of husband or wife **Ellen Day**  
 6. (c) Age of husband or wife if alive **68** years  
 7. Birth date of deceased **10 or 17 1864**  
 (Month) (Day) (Year)

**8. AGE:** Years **79** Months **2** Days **12** If less than one day hr. min.

9. Birthplace **Mo** (City, town, or county) **O** (State or foreign country)

10. Usual occupation **Salesman**

11. Industry or business

12. Name **Met Day**

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

14. Maiden name  
 15. Birthplace **9** (City, town, or county) (State or foreign country)

16. (a) Informant **Marshall S Day**

(b) Address **Dean Mo R 3**

17. (a) (Burial, cremation, or removal) (b) Date thereof **Nov 30 1943**  
 (Month) (Day) (Year)

(c) Place: burial or cremation **Springfield Mo**

18. (g) Signature of funeral director **J. M. Thompson et al**

(b) Address **Springfield Mo**

19. (a) **12-24-43** (b) **Bullet Jones**  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State **Mez** (b) County **Webster 112**  
 (c) City or town **Waycross R 4**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. (If rural, give location)  
 (e) Citizen of foreign country? (Yes or No) **N**  
 If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Dec** day **29** year **1943** hour **11 P** minute **30** AM.  
 21. I hereby certify that I attended the deceased from **Nov 20** 19**43** to **Dec-27** 19**43**  
 that I last saw h. **1 M** alive on **Dec-27** 19**43**  
 and that death occurred on the date and hour stated above.

Immediate cause of death **Central Hemorrhage** Duration **3 days**  
 Due to **myo Cardial Regeneration** **3 yrs**  
 Due to

Other conditions (Include pregnancy within 3 months of death) **93d**

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 **Dr. J. R. Kille** (M. D. or other) **D.O.**  
 Address **Waycross Mo** Date signed **12/28/43**

1067

FEB 3 1944

RECEIVED

District Health Officer No. 6,

District File Number 144-68

Date Filed JAN 17 1944

*[Handwritten notes and signatures, including "M. C. B." and "Spikes..."]*

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 with the above constitutes grounds for revocation of license.)

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