

**FILED APR 8 1947**

Registration District No. **98**

Primary Registration District No. **4159**

Registrar's No. **28**

**1. PLACE OF DEATH:**

(a) County **Daviess**  
(b) City or town **Pattonsburg**  
(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 **One Month** (Specify whether years, months or days)

**3. (a) PRINT FULL NAME** **Ada Jane Day**

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

4. Sex **F** / 5. Color or race **W** 6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **J.O. Day** 6. (c) Age of husband or wife if alive **X** years  
7. Birth date of deceased **Mar 31 1868**  
(Month) (Day) (Year)

8. AGE: Years **78** Months **10** Days **5** If less than one day hr. min.

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

10. Usual occupation **House Wife**

MOTHER FATHER

11. Industry or business  
12. Name **John Long**  
13. Birthplace **Abington W. Va.**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Elizabeth Green**  
15. Birthplace **W. Va.**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Ica L. Gromer**  
(b) Address **Pattonsburg, Mo**

17. (a) Burial (b) Date thereof **2/9/47**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Berlin, Mo**

18. (a) Signature of funeral director **Robert T. Anderson**  
(b) Address **Pattonsburg, Mo**

19. (a) **3-25-47** (b) **Hugena McGehee**  
(Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**

(a) State **Mo** (b) County **Gentry 38**  
(c) City or town **King City**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location) **1**  
(e) Citizen of foreign country? **no** (Yes or No)  
If yes, name country

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month **Feb** day **6**  
year **1947** hour **3** minute **10 P.M.**

21. I hereby certify that I attended the deceased from **Jan 17**, 19**47**, to **Feb 6**, 19**47**, that I last saw her alive on **Feb 6**, 19**47**, and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Infarction with Central Occlusion & Arrhythmia**  
Due to **Thrombosis**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **g.i.t.** **ADDITIONAL PHYSICIAN SUPPLEMENTARY INFORMATION REQUESTED**  
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) (e) Means of injury  
23. Signature **J. H. Frank** (M. D. or other)  
Address **Pattonsburg Mo** Date signed **2/6/47**

**DISTRICT HEALTH OFFICE  
Cameron, Mo.**

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**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 C. T. Pilcher

Licensed Embalmer No. 3960

P. O. Address. Maysville, 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, fact should be so stated above.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 8449

Registration District No. \_\_\_\_\_

Primary Registration District No. \_\_\_\_\_

Registrar's No. 28

1. PLACE OF DEATH:

(a) County Daniel  
(b) City or town Pattonsburg  
(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

Ada Jane Day

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

5. Color or race \_\_\_\_\_ 6. (a) Single, widowed, married, divorced \_\_\_\_\_

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, \_\_\_\_\_ 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)  
(Burial, cremation, or removal)

18. (c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Date received local registrar) (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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb Year 1947  
hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19 \_\_\_\_\_, 19 \_\_\_\_\_

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19 \_\_\_\_\_, and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

arteriosclerosis

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 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 John B. Baker (M. D. or other) \_\_\_\_\_  
Address \_\_\_\_\_ Date signed 7/19/48

SUPPLEMENTARY

MOTHER FATHER

W V

30

WRITE PLAINLY—USE UNFADING BLACK INK—WRITE IN THESE SPACES

