

No. 2
-1747
-1739

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **44549**

Registration District No. **199**

Primary Registration District No. **45486028**

Registrar's No. **1**

1. PLACE OF DEATH:

(a) County **REYNOLDS**

(b) City or town **RURAL - CARL TWP.**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: **NONE**
(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.

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **REYNOLDS**

(c) City or town **RURAL**
(If outside city or town limits, write "RURAL")

(d) Street No. **NEAR CENTERVILLE, MO**
(If rural, give location)

(e) Citizen of foreign country? **NO** (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME **RALPH A. DAY**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **M** race **W**

5. Color or race **W**

6. (a) Single, widowed, married, divorced **M**

6. (b) Name of husband or wife **ETHEL DAY**

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **DEC 25 1882**
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
65	-	6	_____ hr. _____ min.

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

10. Usual occupation **LABORER**

11. Industry or business:

12. Name **ALBERT DAY**

13. Birthplace **NO RECORD** **G**
(City, town, or county) (State or foreign country)

14. Maiden name **LYDIA B. DAY**

15. Birthplace: **NO RECORD** **G**
(City, town, or county) (State or foreign country)

16. (a) Informant **Ethel Day**

(b) Address **CENTERVILLE, MO**

17. (a) **BURIAL** (b) Date thereof **1/13/48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **BEE FORK CEM.**

18. (a) Signature of funeral director **Carl K. Genter**

(b) Address **SALEM, MO**

19. (a) **2-6-48** (b) **C.M. Fitzpatrick** **NO.**
(Date received local registrar) (Registrar's signature) **215**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **DEC.** day **31**
year **1947** hour **2:00** minute **P.** M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw h. _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis of Heart**

Due to **Coronary Thrombosis of Heart**

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

PHYSICIAN

Major findings:
Of operations _____

Of autopsy **94A**

Underline the cause of 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? _____

Means of injury _____

23. Signature **J.R. Pyrtle** **Coroner** (M. D. or other) _____
Address **Centerville Mo** Date signed **Jan 6-48**

90
90
90

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

MOTHER FATHER

FEB 6 1948

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

Wm. W. McDonald

Licensed Embalmer No. 3806

P. O. Address Salem, 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.

No. 2B
3-45
43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

44549
Feb

State File No. _____

Registration District No. 299

Primary Registration District No. 6028

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Reynolds

(b) City or town Rural
(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

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 _____

3. (a) PRINT FULL NAME Ralph A. Way

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 _____

7. Birth date of deceased see 2-5-35
(Month) (Day) (Year)

8. AGE: Years 65 Months _____ Days _____ If less than one day _____ hr. _____ 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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) E. W. S. [Signature]
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I did not see him _____, and that death occurred on the date and hour stated above.
(Immediate cause of death _____)

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

Duration _____

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 _____

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

SUPPLEMENTARY

S-44549