

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **1172**

FILED JAN 28 1954

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **445** PRIMARY REG. DIST. NO. **551b** Registrar's No. **19**

1. PLACE OF DEATH a. COUNTY <b>Iron</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Iron</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>rural - Iron typ</b>		c. CITY OR TOWN <b>Bellevue</b>	
c. LENGTH OF STAY (in this place) <b>Yr's</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>XXX</b>		e. STREET ADDRESS (If rural, give location) <b>0470 on Highway 32, near Bellevue</b>	

3. NAME OF DECEASED (Type or Print) <b>MRS DeLLA DAY</b>	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) <b>Jan 20 1954</b>
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5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>June 20 - 1881</b>	9. AGE (In years last birthday) <b>73</b>	10. MONTHS <b>7</b>	11. DAYS <b>10</b>	12. IF UNDER 14 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>X</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Laundering</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>Iron County, Mo.</b>	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME <b>Marion Keelick</b>	13b. MOTHER'S MAIDEN NAME <b>Francis Dunlap</b>	14. NAME OF HUSBAND OR WIFE <b>John Day</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>X</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Robert Day</b>	ADDRESS <b>Bellevue Mo</b>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Decomposed Cor Pulmonale 2 days</b>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Advanced Pulmonary Emphysema med.</b> DUE TO (c) <b>Chronic Bronchial Asthma years</b>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>241 X</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <b>Bellevue Iron Mo</b>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>Jan 20, '54 2Pm</b>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **Jan 11**, 19**54**, to **Jan 20**, 19**54**, that I last saw the deceased alive on **Jan 19**, 19**54**, and that death occurred at **2:00 Pm**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Paul P. Edgar, M.D.</b>	23b. ADDRESS <b>117 S. Jackson Farmington</b>	23c. DATE SIGNED <b>1-22-54</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Jan 22, 1954</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Bass Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Bass, Missouri</b>
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DATE REC'D BY LOCAL REG. <b>Jan 25 1954</b>	REGISTRAR'S SIGNATURE <b>Mrs. Elizabeth Logan</b>	2. FUNERAL DIRECTOR'S SIGNATURE <b>[Signature]</b>	ADDRESS <b>[Address]</b>
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WRITE PLAINLY—USING 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 ....., Student Embalmer No..... working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed.....  
*Carl H. Jensen*

Licensed Embalmer No. *23*

P. O. Address *Salem*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.