

V. S. No. 300
REV. 10-48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED JAN 13 1958

State File No. **45745**
12620

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Jasper 0495			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Missouri		c. LENGTH OF STAY (in this place) 67 Days		c. CITY OR TOWN Joplin		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Children's Hospital 2310				e. STREET ADDRESS (If rural, give location) 805 Broadway			
3. NAME OF DECEASED (Type or Print) a. (First) Billy b. (Middle) Dean c. (Last) Day			4. DATE OF DEATH (Month) (Day) (Year) 12-28-57				
5. SEX <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, SEPARATED NEVER MARRIED		8. DATE OF BIRTH 7-5-93	
9. AGE (In years last birthday) 14		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 Wk. Hours _____ Mins. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) Webb City, Missouri		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME William L. Day			13b. MOTHER'S MAIDEN NAME Hillian Edwards			14. NAME OF HUSBAND OR WIFE None	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME ADDRESS June Mansfield 500 S. Kings Highway			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sacular aneurysm ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arterio Sclerosis DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Braincellosis				INTERVAL BETWEEN ONSET AND DEATH 5 minutes 14 years ?	
19a. DATE OF OPERATION 11-1-57		19b. MAJOR FINDINGS OF OPERATION Aortic Stenosis				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
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) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from 10-22-1957 , to 12-28-1957 , that I last saw the deceased alive on 12-28-1957 , and that death occurred at 6:10 p.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) Don L. Thurston M.D.				23b. ADDRESS 500 S. Kings Highway		23c. DATE SIGNED 12-28-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 12-29-57		24c. NAME OF CEMETERY OR CREMATORY Joplin, Mo.		24d. LOCATION (City, town, or county) (State) Joplin, Mo.	
DATE REC'D BY LOCAL REG. DEC 30 57		REGISTRAR'S SIGNATURE Carl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Albert H. Hoppe 1700 Washington, Blvd.			

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

(Licensed Embalmer's Statement on Reverse Side)

JAN 29 1958

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 *Edmond R. Schwab*

Licensed Embalmer No. *4077*

P. O. Address *St. Louis*

**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.**