

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

**63-014649**  
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 352 Primary Registration District No. \_\_\_\_\_ Registrar's No. 26

DO NOT WRITE ON THIS STUB  
AMENDED

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <b>Taney</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> COUNTY <b>Taney</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Branson</b>		Length of stay in 1b <b>1 week</b>	c. CITY OR TOWN <b>Forsyth</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Skaggs Hosp</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>Forsyth</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JONATHAN LEWIS DAY</b>			4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>1963</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9/11/1875</b>	9. AGE (last birthday) <b>87</b>	IF UNDER 1 YEAR IF UNDER 24 HR Months <b>6</b> Days <b>12</b> Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farmer</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>Henry Day</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Maggard</b>		14. NAME OF HUSBAND OR WIFE <b>Rosa Day</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no none</b>		16. SOCIAL SECURITY NO. [REDACTED]	17. INFORMANT Address <b>Clint Day Los Angeles, Calif.</b>			
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Kruptured Gall Bladder.</b> <b>acute Cholelithiasis.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>MR.</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)				PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/>	SUICIDE <input type="checkbox"/>	HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____		Month, Day, Year _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION	COUNTY	STATE		
21. I attended the deceased from <b>11/1/62</b> to <b>3/23/63</b> and last saw him alive on <b>8 P.M.</b> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <b>Ray Sillissie M.D.</b> (Degree or title)		22b. ADDRESS <b>Branson Mo.</b>		22c. DATE SIGNED <b>3/4/63</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>3/27/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Snapp Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Forsyth, Mo</b>			
24. FUNERAL DIRECTOR <b>Walter Cobb Branson, Mo</b> ADDRESS		25. DATE RECD. BY LOCAL REG. <b>4-1-63</b>	26. REGISTRAR'S SIGNATURE <b>Debra Campbell</b>			

USE BLACK INK OR TYPEWRITER RIBBON

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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 \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer

Signed

*Walter Cobb*

Licensed Embalmer No. 4731

P. O. Address Branney

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.