N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D FEB 10 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

3 791 1003

926
Do not use this space.

926

1. PLACE OF DEATH
(a) County ..... Registration District No. 1
(b) Township ..... Primary Registration District No. ..... Registered No. .....
(c) City St. Louis, Mo. (d) Street No. 500 S. Kingshighway St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Day, John Edward
(a) Residence, No. 5069 Kensington St. 12
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M
4. COLOR OR RACE W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) child
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF child
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-3-38
7. AGE YEARS — MONTHS 3 DAYS 25 If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. child
9. Industry or business in which work was done, as saw mill, bank, etc. child
10. Date deceased last worked at this occupation (month and year) .....
11. Total time (years) spent in this occupation .....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Louis, Mo. 0

FATHER
13. NAME Fred H. Day 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bixby, Missouri. 1

MOTHER
15. MAIDEN NAME Dorothy Humphreys
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Clarksville, Virginia.

17. INFORMANT (ADDRESS) Fred H. Day Adder 5069 Kensington Ave. Kingshighway
18. BURIAL, CREMATION, OR REMOVAL PLACE Salem, Missouri, DATE Jan 31, 1939
19. FUNERAL DIRECTOR (NAME) (ADDRESS) Albert H. Hoppe Inc., 4700 Washington Blvd.,
20. FILED JAN 30 1939 J. F. Bredek Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 28, 1939
22. I HEREBY CERTIFY, That I attended deceased from 1-26-, 1939, to 1-28-, 1939
I last saw him alive on 1-29-, 1939. Death is said to have occurred on the date stated above, at 2 45 a.m.
The principal cause of death and related causes of importance were as follows:

congenital heart disease — Date of onset birth

Other contributory causes of importance:

Name of operation ..... Date of .....
What test confirmed diagnosis? ..... Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19....
Where did injury occur? ..... (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) [signature], M. D.
(Address) 500 So. Kingshighway

(Licensed Embalmer's Statement on Reverse Side)

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 Guy W Wilkinson

Licensed Embalmer No. 3575

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.