

FILED NOV 19 1943  
Registration District No. 72

Primary Registration District No. 1000

Registrar's No. 1091

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Saint Joseph  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 9 days  
(Specify whether years, months or days)

In this community 79 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

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

(d) Street No. 104 1/2 North 2nd St  
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country NO

3. (a) PRINT FULL NAME John James Day

3. (b) If veteran, name war NONE

3. (c) Social Security No. NONE

4. Sex Male 5. Color or Race White

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased May 5, 1864  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

|    |   |   |          |
|----|---|---|----------|
| 79 | 4 | 6 | hr. min. |
|----|---|---|----------|

9. Birthplace Taos Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name John Day

13. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)

14. Maiden name Katherine Walker

15. Birthplace Unknown Virginia  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Kenneth Lee

(b) Address Route #4, St. Joseph, Mo.

17. (a) Burial (b) Date thereof Sept. 13, 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Fancett Cemetery

18. (a) Signature of funeral director Mrs. E. R. Sidenfaden

(b) Address 602 South 10th Street

19. (a) 9-13-43 (b) Core Neigoy  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11  
year 1943 hour 11 minute 48 A.M.

21. I hereby certify that I attended the deceased from Sept 5 1943 to Sept 11 1943  
that I last saw him alive on Sept 11 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death: Emphysema of stomach 7da.  
Ruptured spleen 7da.  
Due to Trauma  
Cerebral hemorrhage 7day.  
Due to Trauma

Other conditions Multiple abrasions, contusions  
and lacerations  
(Include pregnancy within 3 months of death)

Major findings: none

Of operations \_\_\_\_\_

Of autopsy as above  
Information as to occurrence of above  
information to be furnished to coroner

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence 1943

(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? NO

While at work? \_\_\_\_\_  
(Specify type of place) (e) Means of Injury

23. Signature Ed Grant M.D. (M.D. or other)  
Address St. Joseph, Mo. Date signed 9-13-43

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

232  
8-1303  
P. 2617 name

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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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed Mollie E. Sidenfaden Fla.  
Licensed Embalmer No. 4235  
P. O. Address St. Joseph, 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.**