V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 9 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 42081

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 359

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

1. PLACE OF DEATH:
(a) County: PETTIS
(b) City or town: SEDALIA (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BOTHWELL HOSPITAL (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days) In this community ____

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: PETTIS 80
(c) City or town: SEDALIA 6 (If outside city or town limits, write "RURAL")
(d) Street No.: 318 W 10TH ST. 4 (If rural, give location) 1
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: NINA CATHERINE DAY
3. (b) If veteran, name war ____ 3. (c) Social Security No. ____
4. Sex: FEMALE 5. Color or race: WHITE 6. (a) Single, widowed, married, divorced: MAR. 1
6. (b) Name of husband or wife: THOS R. DAY 6. (c) Age of husband or wife if alive: 48 years
7. Birth date of deceased: 4 (Month) 30 (Day) 1874 (Year)

8. AGE: Years	Months	Days	If less than one day
71	7	16	____ hr. ____ min.

9. Birthplace: IND. 1 (City, town, or county) (State or foreign country)
10. Usual occupation: HOUSEWIFE
11. Industry or business ____
MOTHER FATHER
12. Name: ISAAC HECK
13. Birthplace: IND. 1 (City, town, or county) (State or foreign country)
14. Maiden name: MARGARET YOE
15. Birthplace: IND 1 (City, town, or county) (State or foreign country)
16. (a) Informant: MRS. FRED OVERFELT
(b) Address: SEDALIA, MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof: 12-18-45 (Month) (Day) (Year)
(c) Place: burial or cremation: MEM. PARK
18. (a) Signature of funeral director: Geo Dillard
(b) Address: SEDALIA
19. (a) 12-18-45 (Date received local registrar) (b) A. G. Campbell (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC. day 16 year 1945 hour 5:45 minute A. M.
21. I hereby certify that I attended the deceased from Jan. 46, 19__, to Dec 16 46, 19__, that I last saw her alive on Dec 16 45, and that death occurred on the date and hour stated above.

Immediate cause of death: Cerebrovascular hemorrhage — Duration
Due to: Hypertrophy Cardiac myocarditis
Due to: ____
Other conditions: (Include pregnancy within 3 months of death)
Major findings: Of operations ____ Of autopsy: negative

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ____
(b) Date of occurrence ____
(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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____
Signature: J. Smithwell M.D. (M. D. or other)
Address: Sedalia, Mo Date signed 1-17-46

1486 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 1-8-46

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 L. E. Boulden

Licensed Embalmer No. 3867

P. O. Address Sidalia

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.