

FILED OCT 24 1947 18

Registration District No.

Primary Registration District No.

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

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Missouri Pacific Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 5 days
(Specify whether
In this community
years, months or days)

3. (a) PRINT FULL NAME Raphael F. 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 Married

6. (b) Name of husband or wife Margaret 6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
abt. 61 hr. min.

9. Birthplace Flora Illinois
(City, town, or county) (State or foreign country)

10. Usual occupation Car Foreman

11. Industry or business G.M.N.O. J. Railroad

MOTHER FATHER { 12. Name Joe Day
13. Birthplace unknown
(City, town, or county) (State or foreign country)
14. Maiden name Martha Deuweiss
15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. R. T. Day
(b) Address Granite City, Ill.

17. (a) Cath burial (b) Date thereof Oct. 18, 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Francis J. Sakey
(b) Address Madison, Illinois

19. (a) OCT 10 1947 (b) J. F. Bradech
(Date received from registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Madison
(c) City or town Granite City
(If outside city or town limits, write "RURAL")
(d) Street No. 2690 IOWA
(If rural, give location)
(e) Citizen of foreign country? N.R. (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day ninth
year 1947 hour 10 minute 25 A.M.

21. I hereby certify that I attended the deceased from Oct 7
1947 to Oct 9 1947
that I last saw him alive on Oct 9 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Heart Disease
Due to Hypertensive C-R-V Disease

Due to
Other conditions Ca Of Prostate
(Include pregnancy within 3 months of death)

PHYSICIAN
Major findings:
Of operations
Of autopsy Kidney Degeneration, Hypertrophy of Heart
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?

While at work? (Specify type of place) (a) Means of injury
23. Signature Vincent A. Sherrard (M. D.)
Address 200 - Prec. Hosp. Date signed 10-9-47

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.....

Dennis J. Lahey

Licensed Embalmer No. *27912*

P. O. Address *Madison Ill.*

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.