

FILED DEC 28 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

41971

State File No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **10572**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>St. Louis</b>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Ferguson</b>	
c. LENGTH OF STAY (In this place) <b>2 Days</b>		d. STREET ADDRESS (If rural, give location) <b>628 January Ave.</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>DePaul Hospital</b>			
3. NAME OF DECEASED (Type or Print) a. (First) <b>James</b> b. (Middle) <b>William</b> c. (Last) <b>Day</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Dec. 1, 1955</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 12, 1886</b>
9. AGE (In years last birthday) <b>69</b>	IF UNDER 1 YEAR Months	IF UNDER 22 yrs. Days	IF UNDER 22 yrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Automotive</b>	11. BIRTHPLACE (State or foreign country) <b>Hillsboro, Ohio</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>
13a. FATHER'S NAME <b>Frank Day</b>	13b. MOTHER'S MAIDEN NAME <b>Adelaide Wright</b>	14. NAME OF HUSBAND OR WIFE <b>May Willis Day</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>	16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>277-03-8429</b>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mrs. May Day, Ferguson, MO.</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>MYOCARDIAL INFARCTION</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b>  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Small rupture of myocardium</b>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4200 4201</b>	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov 29 1955</b> to <b>Dec 1, 1955</b> , that I last saw the deceased alive on <b>Dec 1, 1955</b> and that death occurred at <b>9:50 P.M.</b> , from the causes and on the date stated above.			
23a. SIGNATURE (Degree or title) <b>Walter B. Kutzky M.D.</b>		23b. ADDRESS <b>5664 Ashland</b>	23c. DATE SIGNED <b>12/2/55</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>12-3-55</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Glen Rest Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Colombus, Ohio.</b>
DATE REC'D BY LOCAL REG. <b>DEC 2 1955</b>	REGISTRAR'S SIGNATURE <b>W. C. Smith M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>White Funeral Home, Ferguson, Mo.</b>	

(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 \_\_\_\_\_

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

working under my personal supervision.

Student \_\_\_\_\_  
Student Embalmer

Signed \_\_\_\_\_

*E. L. Province*

Licensed Embalmer No. \_\_\_\_\_

*3403*

P. O. Address \_\_\_\_\_

*Jennings*

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

If this body is not embalmed, fact should be so stated above.