FEB 21 1928

DeKalb

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

Do not use this space. 620

1. PLACE OF DEATH
County Maysville — Registration District No. 259
Township ~~Sandusville~~ — Primary Registration District No. 4138
City ..... (No. ..... St. ..... Ward) — File No. ..... Registered No. .....

2. FULL NAME James Lindley Bray

(a) Residence. No. ..... St. ..... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Widowed

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF Margaret Bray

6. DATE OF BIRTH (MONTH, DAY AND YEAR) June 10 1850

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	77	7	6	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Monrovia, Morgan
(STATE OR COUNTRY) Co., Ind

PARENTS
10. NAME OF FATHER Samuel Bray
11. BIRTHPLACE OF FATHER (CITY OR TOWN) .....
(STATE OR COUNTRY) North Carolina
12. MAIDEN NAME OF MOTHER Mary Lindley
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTRY) Ind.

14. INFORMANT Sam L. Bray
(Address) Weatherby Mo.

15. FILED 1/17 1928 J. L. Phelps REGISTRAR

MEDICAL CERTIFICATE OF DEATH

1

16. DATE OF DEATH (MONTH, DAY AND YEAR) January 16th 1928

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st, 1927, to Jan 16th, 1928, that I last saw h[illegible] alive on January 16th, 1928, and that death occurred, on the date stated above, at 7 p. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Senile Decay
162
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY) .....
(duration) 3 yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED At his home
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? No. DATE OF .....
WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Clinical Symptoms
(Signed) John M Brown, M. D
, 19 (Address) Maysville Mo

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Maysville — DATE OF BURIAL 1/18 1928
20. UNDERTAKER J. K. Davis — ADDRESS Maysville

NOTE.—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.