

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

Do not use this space.

15938

File No. 5-2
Registered No. _____
St. _____ Ward _____

1. PLACE OF DEATH

County Haskell Registration District No. 384
Township _____ Primary Registration District No. 5-5-35
City West Plains, Mo. 2/2/11

2. FULL NAME

Francis America 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 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX FW 4. COLOR OR RACE WHT 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>76</u>	<u>3</u>	<u>2</u>	<u>23</u>

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Haskell Co.,
(STATE OR COUNTRY)

PARENTS	10. NAME OF FATHER <u>Reg Davis</u>
	11. BIRTHPLACE OF FATHER (CITY OR TOWN) <u>unknown</u> (STATE OR COUNTRY)
	12. MAIDEN NAME OF MOTHER " "
	13. BIRTHPLACE OF MOTHER (CITY OR TOWN) " " (STATE OR COUNTRY)

14. INFORMANT Fred Bray
(Address) West Plains Mo

15. FILED 5-21-30 O.P.A. Heinrich
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 5/16-1930

17. I HEREBY CERTIFY, That I attended deceased from April 28, 1930, to April 28, 1930.
that I last saw her alive on April 28, 1930, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Fibrinous Plethor
23 only saw her breathing.

CONTRIBUTORY (SECONDARY) 31

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

19. DID AN OPERATION PRECEDE DEATH? No. DATE OF _____

20. WAS THERE AN AUTOPSY? No.

WHAT TEST CONFIRMED DIAGNOSIS Physical Symptoms
(Signed) P.A. Sparks, M. D.

5-17-1930 (Address) West Plains 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 <u>Galloway</u>	DATE OF BURIAL <u>5/18 1930</u>
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20. UNDERTAKER <u>McFarlands'</u>	ADDRESS <u>West Plains</u>
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N. B.—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.

