

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

**26151**  
Do not use this space.

**AUG 14 1939**

**1. PLACE OF DEATH**

(a) County Linn Registration District No. 5-06  
 (b) Township Baker Primary Registration District No. 8-671 Registered No. \_\_\_\_\_  
 (c) City New Boston (d) Street No. \_\_\_\_\_  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. \_\_\_\_\_ St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) May 12 1866

7. AGE YEARS 73 MONTHS 2 DAYS 5 If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired  
 9. Industry or business in which work was done, as saw mill, bank, etc. \_\_\_\_\_  
 10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

FATHER 13. NAME Carroll B. Bray

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind

MOTHER 15. MAIDEN NAME Malinda Hester

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ind

17. INFORMANT (ADDRESS) Tilda Hester

18. BURIAL, CREMATION, OR REMOVAL PLACE Hester Chapel July 19, 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) W. W. McCollum  
South Lufford Mo

20. FILED July 22 1939 Bertrude Williams  
Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) July 17 1939

22. I HEREBY CERTIFY, That I attended deceased from July 17 1939 to July 17 1939  
 Last seen alive on July 17 1939. Death is said to have occurred on the date stated above, at 8-30 a.m.  
 The principal cause of death and related causes of importance were as follows:

Coronary Occlusion Date of onset 9-2-38  
 Other contributory causes of importance:  
Chronic Endocarditis  
Angina Pectoris

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? no  
 If so, specify \_\_\_\_\_  
 (Signed) N. G. Longmire M. D. O.  
Bucklin, Mo. (Address)

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.

RECEIVED

District Health Officer No. 11,

District File Number 839-1032

Date Filed AUG 11 1939

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, .....

*W. H. McCallum*

or by .....

Registered Apprentice No. ...., working under my personal supervision.

Signed *W. H. McCallum*

Licensed Embalmer No. 2052

P. O. Address *South Effingham*

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, above space should be left blank.