

No. 2
-10-39
17-39
X21492

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 1736

Registration District No. 85

Primary Registration District No. 1001

Registrar's No. 72

1. PLACE OF DEATH:

(a) County BUCHANAN
(b) City or town ST. JOSEPH
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: MO. METHO. HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 6 days 1
(Specify whether years, months or days)

FILED FEB 23 1940

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County DeKalb
(c) City or town Maysville
(If outside city or town limits, write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

8. (a) PRINT FULL NAME 6 Mollie Bray

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Lulu Bray 6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased April 7 1867
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 14 If less than one day hr. _____ min. _____

9. Birthplace DeKalb (Polk Twp) Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Retired Merchant

11. Industry or business Hardware

12. Name Samuel Bray

13. Birthplace North Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Mary A. Lindley

15. Birthplace Indiana
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Lulu Bray

(b) Address Maysville Missouri

17. (a) Burial (b) Date thereof 1/23-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maysville Cemetery

18. (a) Signature of funeral director Pilcher Funeral Home

(b) Address Maysville Missouri

19. (a) Jan 23/1940 (b) H. S. Conrad
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21
year 1940 hour 10 minute A.M.

21. I hereby certify that I attended the deceased from Jan 18
1940, to Jan 21, 1940
that I last saw him alive on Jan 21, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive pneumonia Duration Jan 19

Due to Perforated gangrenous appendix

Due to Chronic myocarditis Chronic asthma 21

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations Perforated gangrenous appendix with abscess
Of autopsy None

PHYSICIAN

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? _____

(Specify type of place) (e) Means of injury _____

23. Signature H. S. Conrad (M. D. or other) _____

Address St Joseph Mo Date signed Jan 21-40

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

MOTHER FATHER

37

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

[Handwritten Signature]

Licensed Embalmer No. 1937

P. O. Address

[Handwritten Address]

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.