DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 6735

FILED MAR 16 1940

Registration District No. 647   Primary Registration District No. 3018   Registrar's No.

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

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.

1. PLACE OF DEATH:
(a) County Henry Co.
(b) City or town Clinton Mo Clinton Twn
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Clinic Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution Feb 4th to 6, 1940
In this community 2 Days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Clair
(c) City or town Lowry City (Rural)
(If outside city or town limits, write "RURAL")
(d) Street No. 4½ Mile East & North
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Erma Kelly Bray (S.R.)
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband ~~or wife~~ Earl C Bray
Earl C. Bray
6. (c) Age of husband ~~or wife~~ if alive 32 years
7. Birth date of deceased July (Month) 18 (Day) 1906 (Year)
8. AGE: Years 33 Months 6 Days 18 If less than one day hr. min.
9. Birthplace Lowry City, St Clair Co (City, town, or county) Missouri (State or foreign country)
10. Usual occupation School Teacher & Housewife
11. Industry or business ✓
FATHER
12. Name Thos A Kelly
13. Birthplace Lowry City St Clair Co (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name May Kelly
15. Birthplace Lowry City St Clair Co (City, town, or county) Missouri (State or foreign country)
16. (a) Informant's own signature Dulsie Kelly Bray
(b) Address Lowry City Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/8/1940 (Month) (Day) (Year)
(c) Place: burial or cremation Lowry City Cemetery
18. (a) Signature of funeral director H. C. Austin
(b) Address Lowry City Mo
19. (a) 2-29-40 (Date received local registrar) (b) Dr. J. R. Hampton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month February day 6th year 1940 hour 1st minute 15 A. M.
21. I hereby certify that I attended the deceased from 2-5-40, 19 , to 2-6-, 1940, that I last saw her alive on 2-6-, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Intestinal obstruction	24 hr
Due to Post-op adhesions	
Due to	
Other conditions Cardiac failure (Include pregnancy within 3 months of death)	
Major findings: Of operations Intestinal obstruction	PHYSICIAN Underline the cause to which death should be charged statistically.
Of autopsy	

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)
While at work? (e) Means of injury
23. Signature J. R. O'Neill (M. D. ~~or other~~)
Address Clinton Mo   Date signed 2-6-40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39

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 H. C. Austin

Licensed Embalmer No. 3609

P. O. Address Lawry City Mo

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.