

FILED APR 18 1940

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

9999

Do not use this space.

1. PLACE OF DEATH

(a) County Adair Registration District No. 4
 (b) Township _____ Primary Registration District No. 3001 Registered No. 74
 (c) City Kirkville (d) Street No. Laughlin Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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. 608 Mr. George Brady St. Richland Iowa
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>widowed</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Cora Brown</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Oct. 27-1867</u>		
7. AGE YEARS <u>72</u>	MONTHS <u>5</u>	DAYS <u>0</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Farming</u>		11. Total time (years) spent in this occupation <u>55</u>
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)		
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Jefferson County, Iowa</u>		
13. NAME <u>Jerry Bray</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>North Carolina</u>		
15. MAIDEN NAME <u>Tempy Greenow</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>North Carolina</u>		
17. INFORMANT (ADDRESS) <u>Walter L. Bray, Richland, Iowa R. 2</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Fairfield, Iowa</u> DATE <u>3/27/40</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Mark Huskins, Fairfield, Iowa</u>		
20. FILED <u>Mar. 27, 1940</u> <u>Spencer S. Freeman</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) March 27, 1940

22. I HEREBY CERTIFY, That I attended deceased from March 7, 1940 to March 27, 1940
 I last saw him/her alive on March 27, 1940. Death is said to have occurred on the date stated above, at 6:40 P.M.
 The principal cause of death and related causes of importance were as follows:
septicemia

Other contributory causes of importance:
1. Bilateral varicocele 3-11-40
2. Transurethral prostatectomy
 Name of operation A. resection Date of 3-19-40
 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) Wm. H. Brant D. O.
3 (Address) Kirkville, Mo.

127

RECEIVED

District Health Officer No. 10

District File Number 4-402851

Date Filed APR 16 1940

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.....

Licensed Embalmer No.....

P. O. 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.

Registration District No. **4**

Primary Registration District No. **3001**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Scircenville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether
In this community _____ years, months or days)

3. (a) PRIN
FULL

Mr. George Bray

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **wid**

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years **72** Months **5** Days **0** If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Mar** day **27**
year **1940** hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death **Septicemia**
Due to _____
Due to _____

Other conditions **Bilateral Vasectomy**
(Include pregnancy within 3 months of death)
Transurethral Prostatic PHYSICIAN
Major findings: **resection for**
Of operations **hypertrophy**
Of autopsy _____
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? _____

While at work? _____ (Specify type of place) _____ Means of injury _____

23. Signature **Wm H. Bravel, D.O.** (M.D. or other) _____
Address **Scircenville** Date signed _____

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

SUPPLEMENTARY

S-9999 1940