DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14147

Registration District No. 11 | Primary Registration District No. 5014 | Registrar's No. 28

1. PLACE OF DEATH:

(a) County: Andrew

(b) ~~City or town~~: Rural Clay Twp

(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 years, months or days)

In this community: 79 yrs

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: andrew

(c) City or town: Rural Clay Township

(If outside city or town limits, write "RURAL")

(d) Street No.: 5 Miles south of Graham

(If rural, give location)

(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: Amy Ann Rayhill 450

3. (b) If veteran, name war: ------

3. (c) Social Security No.: -----

4. Sex: female

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Calob Rayhill

6. (c) Age of husband or wife if alive: --- years

7. Birth date of deceased: August (Month) 27 (Day) 1860 (Year)

8. AGE: Years 79 | Months 7 | Days 6 | If less than one day ____ hr. ____ min.

9. Birthplace: New POint (City, town, or county) Mo (State or foreign country)

10. Usual occupation: house wife

11. Industry or business: 0

FATHER

12. Name: William Cline

13. Birthplace: un Known (City, town, or county) (State or foreign country)

MOTHER

14. Maiden name: Amanda Marion

15. Birthplace: un Known (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mrs. Lulu Fields

(b) Address: Graham Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: April 5 40 (Month) (Day) (Year)

(c) Place: burial or cremation: Fair view near New Point

18. (a) Signature of funeral director: E. L. Breit

(b) Address: Savannah Mo.

19. (a) 4-5-40 (Date received local registrar) (b) Mrs. Addie Barnes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 3 year 1940 hour 5 minute 25 P. M.

21. I hereby certify that I attended the deceased from March 19, 1940, to April 3, 1940; that I last saw her alive on April 3, 1940; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary Congestion	3 days
Due to: Cardiac Failure	10 days
Due to: Hypertension	No Data
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations: ✓
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)

While at work? (e) Means of injury:

23. Signature: M. L. Halliday (M. D. or other) MD

Address: Fillmore Mo. Date signed: 4-4-40

(Licensed Embalmer's Statement on Reverse Side)

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.

1118

RECEIVED
District Health Officer No. 11,
District File Number 546-645
Date Filed MAY 6 1948

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 E. C. Breit

Licensed Embalmer No. 2650

P. O. Address Savannah Ma

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14147

Registration District No. 11 Primary Registration District No. 6014 Registrar's No. 28

1. PLACE OF DEATH:

(a) County Andrew

(b) ~~City or town~~ Clay - T. P.
(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)

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.

3. (a) PRINT FULL NAME Amy Ann Rayhill

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

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 79 Months 7 Days 6 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 4 day 3
year 1940 hour minute M.

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

	Duration
Immediate cause of death Pulmonary Congestion	3 da
Due to Cardiac failure	10 day
Due to Hypertension Cardiac Chronic Myocardial Insufficiency	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

93 D²

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)
While at work? (e) Means of injury

23. Signature M. L. Holliday (M. D. or other)
Address Fillmore Date signed

SUPPLEMENTARY