

Registration District No. 934

Primary Registration District No. 6235

Registrar's No. 6235

1. PLACE OF DEATH:
(a) County Ray County Mo
(b) City or town Ray Mo
(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 S
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Wm Kelly Kircail
3. (b) If veteran, name war 0
3. (c) Social Security No. 0

4. Sex Male 5. Color or race Wht 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Margaret (c) Age of husband or wife if alive 62 years
7. Birth date of deceased Aug 2 1870
(Month) (Day) (Year)

8. AGE: Years 70 Months 1 Days 19 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business
12. Name Milton Kircail
13. Birthplace Ray County Mo
(City, town, or county) (State or foreign country)
14. Maiden name Ida Marie
15. Birthplace Ill
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Margaret Kircail
(b) Address Cowgill Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 23-40
(Month) (Day) (Year)
(c) Place: burial or cremation Antioch Ray Co Mo

18. (a) Signature of funeral director Chas R. Reed
(b) Address Cowgill Mo
19. (a) Oct 1-40 (Date received local registrar) (b) Margaret Kircail (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Ray
(c) City or town Ray (If outside city or town limits, write "RURAL")
(d) Street No. S (If rural, give location)
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Sept day 21
year 1940 hour 9 minute 30 p M.
21. I hereby certify that I attended the deceased from Aug 8, 1940, to Sept 21, 1940;
that I last saw him alive on Sept 21, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death Acute edema of Lungs. Duration
Due to Chronic Myocarditis & Myocardial Degeneration
Due to Mitral & Aortic Regurgitation, Aortic Aneurysm & Sclerosis of Liver
Other conditions
(Include pregnancy within 3 months of death)

Major findings: as above
Of operations
Of autopsy
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?
While at work? (Specify type of place) (e) Means of injury 3
23. Signature Dr. H. C. Johnson (M.D. or other) D.O.
Address Cowgill Mo Date signed 9-23-40

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very im-

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-11-40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32936**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **914**

Primary Registration District No. **6235-**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Ray**
(b) City **Grape Grove**
(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) PRINT FULL NAME **Wm Kelley Kincaid**

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

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

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 **70** Months **1** Days **19** 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) **Wm Louis Mancus** (Registrar's signature)
(Date received local registrar) (Date)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Ray**
(c) City or town **Cowdell**
(If outside city or town limits, write "RURAL")
(d) Street No. **Grape Grove Loop** (If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **21**
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 _____

Due to _____

Due to _____

Other conditions: (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

Duration

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? _____

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

23. Signature **G. E. Johnson** (M. D. or other) _____

Address **Cowdell** Date signed _____

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

SUPPLEMENTAL

