

11-10-39
5-17-39
I X21492

Registration District No. **248** Primary Registration District No. **534** Registrar's No. _____

1. PLACE OF DEATH:

(a) County Daviess Co.

(b) City or town Hamilton
(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

3. (a) PRINT FULL NAME SILUS M. CRAY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex male

5. Color or race white

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

6. (b) Name of husband or wife Jeanetta McCreary

6. (c) Age of husband or wife if alive 81 years

7. Birth date of deceased July 16 1859
(Month) (Day) (Year)

8. AGE:

| | | | |
|-----------|----------|-----------|----------------------|
| Years | Months | Days | If less than one day |
| <u>81</u> | <u>3</u> | <u>15</u> | hr. _____ min. _____ |

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

10. Usual occupation farmer

11. Industry or business _____

MOTHER FATHER

12. Name James McCreary

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

14. Maiden name Mary Lynch

15. Birthplace Daviess Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James H. McCray

(b) Address Hamilton Mo.

17. (a) burial (b) Date thereof Nov. 3rd 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McCreary cemetery

18. (a) Signature of funeral director G. W. Haughton

(b) Address Hamilton Mo.

19. (a) 1-30-40 (b) Wm & E. P. ...
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Daviess

(c) City or town Rural
(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 Oct day 31
year 1940 hour 4 minute P.M.

21. I hereby certify that I attended the deceased from October 26, 1940, to _____, 1940;
that I last saw him alive on Oct 31, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Cardiac asthma

edema of lungs

Due to cardio-renal disease

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) asst

PHYSICIAN

Major findings: _____

Of operations _____

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 _____

Where did injury occur? _____ (City or town) (County) (State)

(2) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? 225 (Specify type of place)

(c) Means of injury _____

23. Signature Hubert R. Booth (M. D. or other) M.D.
Address Hamilton Mo. Date signed 11/2/40

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

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.....

L.R. Houghton

Registered Apprentice No.....

working under my personal supervision

Signed

L.R. Houghton

Licensed Embalmer No.....

3854

P. O. Address.....

Hamilton

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 42347

Registration District No. 248

Primary Registration District No. 0345-

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Dyers
(b) City or town Sheridan
(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 OF

Silas Mc Crary

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 married

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

Months

Days

If less than one day

81

3

15-

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 _____

(Burial, cremation, or removal)

(Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) Mr. L. Peiron

(Date received local registrar)

(Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 31
year 1948 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)

Means of injury _____

23. Signature Herbert M. Boathes (M. D. or other)

Address Hamilton Date signed _____

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

SUPPLEMENTARY

