

UG 14 1941

Registration District No. **627**

Primary Registration District No. **5829**

Registrar's No. _____

1. PLACE OF DEATH

(a) County **Nodaway** *Union Twp*
(b) City or town **Pickering** *Rural*
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **3 1/2 miles South East**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **31 yrs.** (years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Nodaway**
(c) City or town **Pickering** *Rural*
(If outside city or town limits, write "RURAL")
(d) Street No. **3 1/2 mi. South East**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **MINERVA CAROLINE WRAY**

3. (b) If veteran, name war **no.** 3. (c) Social Security No. **none**

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

6. (b) Name of husband or wife **Alvin A. Wray** 6. (c) Age of husband or wife if alive, years **apr. 21, 1858**

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

8. AGE: Years **8.3** Months **3** Days **7** If less than one day hr. min.

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

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **John W. Smith**

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

14. Maiden name **Rachael Lancaster**

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

16. (a) Informant **John Wray**

(b) Address **Pickering Mo.**

17. (a) **Burial** (b) Date thereof **July 30, 1941** (Month) (Day) (Year)

(c) Place: burial or cremation **myrtle tree**

18. (a) Signature of funeral director **Price Funeral Home**

(b) Address **Marquette Mo.**

19. (a) _____ (b) **Mrs E C Hackett** (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **28** year **1941** hour **11** minute **20 PM** M.

21. I hereby certify that I attended the deceased from **Oct 7, 1940** to **July 28, 1941**
that I last saw him alive on **July 24, 1941**
and that death occurred on the date and hour stated above.

Immediate cause of death **Asphyxia**
Pneumonia
Due to **Pneumonitis** Duration **5 days**

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) _____

23. Signature **E. C. Hackett** (M. D. or other) _____

Address **Pickering Mo.** Date signed **7-30-41**

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

X28390

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. *3229.*

P. O. Address *Maryville 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, fact should be so stated above.

STANDARD CERTIFICATE OF DEATH

State File No. 25745

Registration District No. 627

Primary Registration District No. 5829

Registrar's No.

1. PLACE OF DEATH:

(a) County Rodgway
(b) City or town Edsersburg rural
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minerva C Gray

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

4. Sex F 5. Color or race W

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 _____ 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) (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 July Day _____ Year 1941 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death pneumonia Duration _____
Due to arthritis

Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: 108
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)
(b) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? _____ (c) Means of injury _____
23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

25745

State File No.

Registration District No. 627

Primary Registration District No. 5829

Registrar's No.

1. PLACE OF DEATH:

(a) County nodaway
(b) City or town Pickering Rural
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Minerva C. Gray

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

4. Sex F 5. Color or race wh 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 Months Days If less than one day _____ min.

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

10. Usual occupation

11. Industry or business

MOTHER FATHER { 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

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

19. (a) July 3, 1944 (b) Mrs. Mary Hackett
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July year 1944 hour _____ minute _____ M.

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

Duration

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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)

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

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY