DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 15 1941

X21492

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

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 31278

Registration District No. 133 | Primary Registration District No. 4074 | Registrar's No. 8

1. PLACE OF DEATH:
(a) County: Carroll
(b) City or town: Bogard, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: No. 1
(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: 50 years.

2. USUAL RESIDENCE OF DECEASED:
(a) State ____ (b) County: 17
(c) City or town: 8
(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: Cora Gray
3. (b) If veteran, name war: No.
3. (c) Social Security No.: No.
4. Sex: Female
5. Color or race: White
6. (a) Single, widowed, married, divorced: Widowed
6. (b) Name ~~of husband or wife~~: Jim Gray
6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: Dec (Month) 4 (Day) 1871 (Year)
8. AGE: Years 69 | Months 8 | Days 29 | If less than one day ____ hr. ____ min.
9. Birthplace: Illinois (City, town, or county) (State or foreign country)
10. Usual occupation: House Keeper
11. Industry or business: No.
12. Name (Father): W. Carr Lillian
13. Birthplace (Father): Illinois (City, town, or county) (State or foreign country)
14. Maiden name (Mother): Collins
15. Birthplace (Mother): Illinois (City, town, or county) (State or foreign country)
16. (a) Informant: Leslie Worth
(b) Address: Bogard Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Sept. 5 1941 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt. Zion
18. (a) Signature of funeral director: C. A. Sullivan
(b) Address: Bogard Mo.
19. (a) 9-5-1941 (Date received by local registrar) (b) Jamie Henderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3rd year 1941 hour 7 minute 30 M.
21. I hereby certify that I attended the deceased from Aug 6th, 1941, to Sept 2nd, 1941 that I last saw he alive on Sept. 2nd, 1941; and that death occurred on the date and hour stated above.

Immediate cause of death: Mitral Insufficiency, Chronic Brights disease.
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? ____ (Specify type of place)
While at work? (e) Means of injury ____
23. Signature: W. L. Atwood (M. D. or other)
Address: Carrollton Mo. Date signed 9/4/41

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number 10-13-41
Date Filed

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. A. Duncan

Licensed Embalmer No. 2534

P. O. Address Bergard, M

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

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

No. 2B
—8-21-41
I X29268

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Registration District No. 133 Primary Registration District No. 4074 Registrar's No.

1. PLACE OF DEATH:
(a) County: Carroll
(b) City or town: Bogard
(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: 50 yrs

2. USUAL RESIDENCE OF DECEASED:
(a) State: MO (b) County: Carroll
(c) City or town:
(If outside city or town limits, write "RURAL")
(d) Street No.: Bogard
(If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country:

3. (a) PRINT FULL NAME: Cora Gray
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: W
6. (b) Name of husband or wife:
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: Dec 4 1871 (Month) (Day) (Year)
8. AGE: Years 69 Months 8 Days 28 If less than one day hr. 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) (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) 9-5-1941 (Date received local registrar) (b) Fannie Henderson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 5 year 1941 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	
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)
(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. D. or other)
Address Date signed

SUPPLEMENTARY

S-31278