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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 20 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 15351

Registration District No. 757 | Primary Registration District No. 3036 | Registrar's No. 985

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

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St Joseph Hosp St Charles Mo
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 day (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St Charles 97
(c) City or town St Charles (If outside city or town limits, write "RURAL") 4
(d) Street No. (If rural, give location) 3
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME MINNIE ALBERTA BRAY
3. (b) If veteran, name war None
3. (c) Social Security No. None
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Lonnie Bray
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 18 (Day) 1890 (Year)

8. AGE: Years 51 | Months 8 | Days 15 | If less than one day hr. min.

9. Birthplace Brussels Mo (City, town, or county) (State or foreign country)
10. Usual occupation Housewife
11. Industry or business
MOTHER FATHER
12. Name Andrew Milton Cunningham
13. Birthplace Brussels Mo (City, town, or county) (State or foreign country)
14. Maiden name Martha Elizabeth Cunningham
15. Birthplace Brussels Mo (City, town, or county) (State or foreign country)
16. (a) Informant Lonnie Bray
(b) Address Troy Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 5 42 (Month) (Day) (Year)
(c) Place: burial or cremation Wilson Cemetery
18. (a) Signature of funeral director Wayne McCoy
(b) Address Troy Mo
19. (a) April 5, 1942 (Date received local registrar) (b) Clarence G. Wessler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 3 year 1942 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from April 2, 1942 to April 3, 1942 that I last saw h alive on April 3, 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uremia —	
Due to: Acute nephritis	
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 Vincenta Schmeler (M. D. or other) MD
Address St Charles Mo Date signed Apr 8 42

619 (Licensed Embalmer's Statement on Reverse Side)

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 Wayne McCoy

Licensed Embalmer No. 358

P. O. Address Troy Mo.

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, fact should be so stated above.

. S. No. 2B
GM—8-21-41
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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. 15351

Registration District No. 757 Primary Registration District No. 3036 Registrar's No.

1. PLACE OF DEATH:
(a) County St Charles
(b) City or town St Charles
(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

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 Minnie A. Bray
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 M
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased July (Month) 18 (Day) 1890 (Year)
8. AGE: Years 51 Months 8 Days 15 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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 2 year 1942 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.

	Duration
Immediate cause of death Nephritis	
Due to Secondary to chronic	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 131 f	
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 Vincent A Schneider (M. D. or other) MD
Address St Charles Mo Date signed 6/3/42

SUPPLEMENTARY