

FILED DEC 11 1942

Registration District No. 15

Primary Registration District No. 5068

Registrar's No. 64

1. PLACE OF DEATH:

(a) County Barton
(b) City or town Rural Sheldon R-1
(c) Name of hospital or institution: St. Joseph's Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community 3 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Barton
(c) City or town R-1 Sheldon MO
(If outside city or town limits write "RURAL")
(d) Street No. South-East of Sheldon MO (If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1942 hour 2:00 minute 30 AM
21. I hereby certify that I attended the deceased from Aug 5
_____, 1941, to Nov. 9, 1942
that I last saw him alive on Sept 29, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death: Respiratory failure

Due to Apoplexy

Due to _____

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

Major findings: _____
Of operations _____

Of autopsy _____

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: Dr. Karl K. Bray (M.D. or other) D.O.
Address: Lamar, Mo Date signed 11-7-42

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

8. (a) PRINT FULL NAME Steven J. Bray

3. (b) If veteran, name war None 3. (c) Social Security No. None

4. Sex M 5. Color or Race W 6. (a) Single, widowed, married, divorced Divorced

6. (b) Name of husband or wife Divorced 6. (c) Age of husband or wife if alive Unknown years

7. Birth date of deceased 2 18 79
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Motorman

11. Industry or business Unknown

12. Name Thomas B. Bray

18. Birthplace South Carolina
(City, town, or county) (State or foreign country)

14. Maiden name Marie Bray

15. Birthplace South Carolina
(City, town, or county) (State or foreign country)

16. (a) Informant John Bray
(b) Address R-1 Sheldon, Mo.

17. (a) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director J. B. Buehler & Sons
(b) Address Sheldon, Mo.

19. (a) 11-8-42 (b) Martina Ruel
(Date received local registrar) (Registrar's signature)

1179

RECEIVED

District Health Officer No. 6,

District File Number 1242-1703

Date Filed DEC 9 1942

MAY 12 1958

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.....

Gerald Beeny

Registered Apprentice No. 4302

working under my personal supervision.

Signed: Gerald Beeny

Licensed Embalmer No. 4302

P. O. Address Sheldon, Me.

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.

Registration District No. 15

Primary Registration District No. 5068

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1. PLACE OF DEATH:

(a) County Barton

(b) City or town 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)

3. (a) PRINT FULL NAME Steven J. Bray

3. (b) If veteran, name war.....

3. (c) Social Security No. 0

4. Sex m 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. Feb 2
(Month) (Day) (Year)

8. AGE: Years 62 Months 9 Days 17
(If less than one day min.)

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

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 (b) Date thereof 11-6-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheldon Cemetery

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) Martha Rivers
(Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov Day 2 Year 1942 Minute..... M.

21. I hereby certify that I attended the deceased from.....
....., 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.....

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) (e) Means of injury.....

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

Address..... Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

S-36588 1942