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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 2 1943

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

9620

Registration District No. 42 Primary Registration District No. 1000 State File No. _____ Registrar's No. 346

1. PLACE OF DEATH:
(a) County Buchanan,
(b) City or town Saint Joseph,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri Methodist Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months,
(Specify whether years, months or days) 2 months,

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

3. (a) PRINT FULL NAME Mattie Charlotte Gray,
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 Earl Gray, 6. (c) Age of husband or wife if alive 66 years
7. Birth date of deceased August 22, 1872
(Month) (Day) (Year)

8. AGE: Years 70 Months 6 Days 26 hr. _____ min. _____
If less than one day

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

10. Usual occupation At Home,

11. Industry or business _____

12. Name Robert Harvey,

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

14. Maiden name Rhody Cazel,

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

16. (a) Informant Earl Gray,

(b) Address Blockton, Iowa,

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 3/19/43
(Month) (Day) (Year)

(c) Place: burial or cremation Mt. Ayr, Iowa,

18. (a) Signature of funeral director Walter M. Gale
(b) Address 319 So. 10th Street,

19. (a) 3-19-43 (Date received local registrar) (b) Walter M. Gale (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 18th.
year 1943 hour 3:00 minute 40 p. M.

21. I hereby certify that I attended the deceased from April 18, 1943 to March 18, 1943
that I last saw her alive on March 19, 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Second & third degree burns of both hands & right arm
Due to explosive touch
Due to _____

Other conditions Sexichitris ulen
(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) accident
(b) Date of occurrence 1-18-43
(c) Where did injury occur? at home Blockton Ia
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In home
While at work? _____ (Specify type of place)
(e) Means of injury _____
23. Signature S. D. Wilson (M. D. or other)
Address St Joseph Mo Date signed 3-18-43

Duration
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

AUG 28 1944
AUG 29 1944

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 3/100/4
....., Registered Apprentice No.
working under my personal supervision.

Signed Frank A. Bowman

Licensed Embalmer No. 1710

P. O. Address St. Joseph M.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9622
Registrar's No. 346

Registration District No. 42 Primary Registration District No. 1000

1. PLACE OF DEATH:
(a) County Buchanan
(b) City or town St Joseph
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: mo. methodist hosp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 months (Specify whether years, months or days)
In this community 2 months

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 Mathis C. Gray
3. (b) If veteran, name war..... 3. (c) Social Security No.....

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month March 1943 year, hour 6:30 minute 18 M.
21. I hereby certify that I attended the deceased from 1943 to 1943 that I saw him live on and that death occurred on the date and hour stated above. Immediate cause of death MI Duration 18

4. Sex M 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 66 years (Month) (Day) (Year)

7. Birth date of deceased Aug 22 (Month) (Day) (Year)
8. AGE: Years 70 Months 6 Days del. If less than one day del. 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).....

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) accident
(b) Date of occurrence Jan 18, 1943
(c) Where did injury occur? Dobson (City or town) (County) (State) La
(d) Did injury occur in or about home, on farm, in industrial place, in public place? In home
While at work..... (Specify type of place) St Joseph
Means of injury caught foot on track
23. Signature S. P. Lewis M.D. (M. D. or other) to civil
Address St Joseph Mo Date signed 4-26-43

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

MOTHER FATHER

SUPPLEMENTARY

JUN 1 9 1944

MAR 3 1944