

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **17876**

Registration District No. **91844**

Primary Registration District No. **4164**

Registrar's No. **60**

31  
0  
0

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

1. PLACE OF DEATH:

(a) County **Daviess**

(b) City or town **Altamont**  
(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 **5 Months** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Jacob B. Gray**

3. (b) If veteran, name war **None**

3. (c) Social Security No. **None**

4. Sex **Male**

5. Color or race **White**

6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Leora Gray**

6. (c) Age of husband or wife if alive **63** years

7. Birth date of deceased **October 24 1878**  
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<b>65</b>	<b>7</b>	<b>3</b>	hr. min.

9. Birthplace **Daviess County Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business **Agriculture**

12. Name **Dennis C. Gray**

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

14. Maiden name **Lyda Ann Carey**

15. Birthplace **Logan County Ohio**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. J. B. Gray**

(b) Address **Altamont, Missouri**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **5-31-1944**  
(Month) (Day) (Year)

(c) Place: burial or cremation **Crab Orchard Cemetery**

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

(b) Address **Gallatin, Mo.**

19. (a) **6-1-1944** (Date received local registrar) (b) **L. O. Fisherson** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Daviess**

(c) City or town **Altamont**  
(If outside city or town limits, write "RURAL")

(d) Street No. **none** (If rural, give location)

(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **27** year **1944** hour **5** minute **30** P. M.

21. I hereby certify that I attended the deceased from **May 7, 1944** to **May 27, 1944**, that I last saw him alive on **May 27, 1944**, and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of lower lip and jaw**

Due to **several yrs.**

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations **45a**

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 **Frank Wilson** (M.D. or other)  
Address **Wentzton** Date signed **6/1/44**

Duration  
From  
history  
several  
yrs.  
PHYSICIAN  
Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

1084

APR 3 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.....

....., Registered Apprentice No. ....

working under my personal supervision.

Signed.....

*L. O. Richesson*

Licensed Embalmer No. ....

*3302*

P. O. Address.....

*Tallahassee*

**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.**