

FILED MAY 17 1944  
Registration District No. 287

Primary Registration District No. 5755

State File No. \_\_\_\_\_

Registrar's No. 49

1. PLACE OF DEATH:

(a) County Maries  
(b) City or town Rural-Jackson Sup  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(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 Elaine Bray

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Fe 5. Color or race White 6. (a) Single, widowed, married, divorced S O  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 23, 1944  
(Month) (Day) (Year)

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day  
1 hr. 15 min.

9. Birthplace Maries Co., Mo.  
(City, town, or county) (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Millard Anderson Bray  
13. Birthplace Paydown, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Orpha Irene Brown  
(City, town, or county) (State or foreign country)  
15. Birthplace Vienna, Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. M. A. Bray  
(b) Address Vienna, Mo.

17. (a) Burial (b) Date thereof Mar. 24, '44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Union Hill

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) 4-4-44 (b) Cerna Bassett  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Maries  
(c) City or town Rural  
(If outside city or town limits, write "RURAL")  
(d) Street No. Jackson Sup  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 23  
year 1944 hour 11 minute 15 A. M.

21. I hereby certify that I attended the deceased from Mar. 23, 1944 to Mar. 23, 1944  
that I last saw her alive on March 23, 1944  
and that death occurred on the date and hour stated above.  
Immediate cause of death Prematurity Duration \_\_\_\_\_

Due to Rubeola (Mother)

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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_

23. Signature S. C. Howard (M. D. or other) D.  
Address Vienna, Mo. Date signed 3/31/44

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-15-44

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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.....

Licensed Embalmer No.....

P. O. Address.....

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.