

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

2777

FILED JAN 16 1945

Registration District No.

Primary Registration District No.

4287

Registrar's No.

1. PLACE OF DEATH:

- (a) County Lincoln
(b) City or town Gray
(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 In This Community
years, months or days 30 yr.

3. (a) PRINT FULL NAME EMMA JANE GAYSE

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Mar 1 1872
(Month) (Day) (Year)

8. AGE: Years 72 Months 7 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name William Colbert

13. Birthplace Lincoln Co. Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Ellen Head

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

16. (a) Informant Hubert Gayse

(b) Address Gray Mo.

17. (a) Burial (b) Date thereof 10-18-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Alexander Ben.

18. (a) Signature of funeral director Wayne M. Bay

(b) Address Gray Mo.

19. (a) Dec 30/44 (b) Mrs. F. Jackson
(Date received local registrar) (Registrar's signature)

(Locate Embalmers Statement on Reverse Side)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Lincoln
(c) City or town Gray Mo.
(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 Oct day 16
year 1944 hour 5 minute 15 P. M.

21. I hereby certify that I attended the deceased from Oct 15
1944 to Oct 16, 1944
that I last saw him alive on Oct 16, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

CORONARY ARTERY Disease.
(C. O. C. in 100%)

Due to _____

Generalized Atherosclerosis.

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?

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature J. L. Greer (M. D. or other) _____
Address Gray Mo. Date dictated Oct 18/44

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 1-15-45

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 Mc Coy

Licensed Embalmer No. 3586

P. O. Address.....

Troy Mo.

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.