

FILED FEB 21 1945

Registration District No. 376

Primary Registration District No. 6075

Registrar's No. 288

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town Farmington, R. F. D. No. 4, Mo.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Francis' 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 \_\_\_\_\_ years, months or days

3. (a) PRINT FULL NAME

Mr. John H. Bray

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

3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Jessie 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased May 30 1862  
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 29 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

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

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

12. Name Mr. Joseph D. Bray  
13. Birthplace Knoxville, Tennessee  
(City, town, or county) (State or foreign country)  
14. Maiden name Louisa Messamore  
15. Birthplace Knoxville, Tennessee  
(City, town, or county) (State or foreign country)

16. (a) Informant My John W. Miss Grace Bray  
(b) Address Farmington, R. F. D. No. 4, Mo.

17. (a) Burial (b) Date thereof Jan 21 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Park View Farmington, Mo.

18. (a) Signature of funeral director Alvin W. Hood

(b) Address 203 Cherry St. Flat 2, Farmington, Mo.

19. (a) 1-31-45 (b) J. J. J. J. J.  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois  
(c) City or town Farmington, R. F. D. No. 4, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. St. Francis' Hosp  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 29  
year 1945 hour 1 minute 0 A. M.

21. I hereby certify that I attended the deceased from Jan 1 1940 to Jan 29 1945  
that I last saw him alive on Jan 28 1945  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary thrombosis Duration 5 years  
Myocardial Disease 4 yrs.

Other conditions Coronary T  
(Include pregnancy within 3 months of death) Myocardial Disease

Major findings: Of operations \_\_\_\_\_ Of autopsy 978

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) While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Geo. J. J. J. (M. D. or other) \_\_\_\_\_  
Address Farmington, Mo. Date signed 1-30-45

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

4100

RECEIVED

District Health Officer No. 4

District File Number 245-278

Date Filed 2-20-45

**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 Alvin W Hood

Licensed Embalmer No. 2780

P. O. Address 303 Crane St. Flat 1, Quincy, Mass.

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 7004  
Registrar's No. 288

Registration District No. 316

Primary Registration District No. 6075

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

1. PLACE OF DEATH:

(a) County St Francis  
(b) City or town Rural St Francis  
(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

John H. Bray

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

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 \_\_\_\_\_ years

7. Birth date of deceased May 30 1945  
(Month) (Day) (Year)

8. AGE: Years 82 Months 7 Days 2 If less than one day \_\_\_\_\_ min.

9. Birthplace St Francis, Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

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

MOTHER FATHER

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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

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

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) James P. Baker  
(Date received local registrar) (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 Jan day 9  
year 1945 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

Duration

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) \_\_\_\_\_  
(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 \_\_\_\_\_ (M. D. or other)

Address \_\_\_\_\_ Date signed \_\_\_\_\_

