

FILED MAY 26 1945

Registration District No. 366

Primary Registration District No. 4535

Registrar's No. 24

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

1. PLACE OF DEATH:
 (a) County WASHINGTON
 (b) City or town MINERAL POINT
 (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 LIFE _____
 years, months or days

2. USUAL RESIDENCE OF DECEASED:
 (a) State MISSOURI (b) County WASHINGTON
 (c) City or town MINERAL POINT _____
 (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 _____

3. (a) PRINT FULL NAME ELSIE GRAY
 (b) If veteran, name war _____
 (c) Social Security No. _____

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month APRIL day 26
 year 1945 hour 9 minute 35 A.M.
 21. I hereby certify that I attended the deceased from APRIL 20, 1945, to APRIL 22, 1945,
 that I last saw her alive on APRIL 22, 1945,
 and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race COLORED
 6. (a) Single, widowed, divorced, SINGLE
 (b) Name of husband or wife _____
 (c) Age of husband or wife if alive _____ years

Immediate cause of death _____
Pneumonia following
Appendicitis Peritonitis
 Due to _____
 following
Valley fever
 and
Malnutrition
 Other conditions (Include pregnancy within 3 months of death) _____
 Major findings Of operation _____
 Of autopsy _____

7. Birth date of deceased: JAN 13 1882
 (Month) (Day) (Year)
 8. AGE: Years Months Days If less than one day
63 3 13 hr. _____ min. _____

Physician _____
 Underline the cause to which death should be charged statistically.
REQUESTED

9. Birthplace OLD MINES MO
 (City, town, or county) (State or foreign country)
 10. Usual occupation HOUSE KEEPER

11. Industry or business _____
 12. Name LOUIS GRAY
 13. Birthplace OLD MINES MO
 (City, town, or county) (State or foreign country)
 14. Maiden name NANCY VAUGHN
 15. Birthplace OLD MINES MO
 (City, town, or county) (State or foreign country)

16. (a) Informant AGNESS GRAY
 (b) Address POTOSI MO
 17. (a) St James Cemetery (b) Date thereof: 4-28-45
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation POTOSI MO
 18. (a) Signature of funeral director Geo. Thurman Home
 (b) Address Potosi MO
 19. (a) 4-27-1945 (b) Geo. L. Thurman
 (Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
 (c) 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) _____ (e) Means of injury _____
 23. Signature W. F. Freshwell (M. D. No. 427/45)
 Address Potosi MO Date signed _____

on 2
-M
X I

RECEIVED

District Health Officer No. 7

District File Number 545-642

Date Filed 5-25-48

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 C. H. Bayn

Licensed Embalmer No. 4158

P. O. Address Topeka, 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.

o. 2B
45
43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. jump
Registrar's No. 2x

Registration District No. 366

Primary Registration District No. 4535

1. PLACE OF DEATH:

(a) County Washington
(b) City or town Sumner
(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

Elsie Gray

3. (b) If veteran, name war

3. (d) Social Security No.

4. Sex F

5. Color or race B

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

6. (b) Name of husband or wife

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

7. Birth date of deceased

Jan 1 1863
(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

hr. 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)

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 _____
year 1963 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____
to _____, 19____

that I last saw him _____ alive on _____, 19____
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Duration

Due to _____

Due to Lobar pneumonia

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 _____

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

SUPPLEMENTARY

18471