

FILED SEP 7 1945 **STANDARD CERTIFICATE OF DEATH**

State File No. 28757

Registration District No. 260

Primary Registration District No. 3076

Registrar's No. 104

1. PLACE OF DEATH:

(a) County Wernier
(b) City or town Neosho
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1405 E. Walnut 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 10 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wernier
(c) City or town Neosho
(If outside city or town limits, write "RURAL")
(d) Street No. 1405 E. Walnut (If rural, give location) 0
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lewis Washington Gray

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married, divorced 1

6. (b) Name of husband or wife Lacey V. Gray 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased April 19 1863 (Month) (Day) (Year)

8. AGE: Years 82 Months 3 Days 15 If less than one day hr. _____ min. _____

9. Birthplace Sungamaw Co. Missouri (City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

12. Name Winkelman 13. Birthplace Idaho (City, town, or county) (State or foreign country)

14. Maiden name _____ 15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant Wallace Gray (b) Address Richard MO

17. (a) Burial (b) Date thereof Aug 6 1945 (Month) (Day) (Year)
(c) Place: burial or cremation Masso Cemetery

18. (a) Signature of funeral director Ferry Funeral Home (b) Address Neosho MO

19. (a) 8-18-45 (Date received local registrar) (b) Hazel B. Burch (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 3 year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from 7-21 1945, to 8-3 1945, that I last saw him alive on 7-27 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral thrombosis - right Duration 13 days

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? _____

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

23. Signature R. B. ... (M. D. or other) _____ Address Neosho, MO Date signed 8-3-45

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

MOTHER FATHER

1331

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

Dist. No. _____ Officer No. 7.

Dist. No. Number 8-45-880

Date Filed 9-9-45

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 Mo
....., Registered Apprentice No.
working under my personal supervision.

Signed R. B. Terry
.....
Licensed Embalmer No. 1760
.....
P. O. Address Nevada, 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. Sept 104
Registrar's No. _____Registration District No. 360Primary Registration District No. 3076

1. PLACE OF DEATH:

(a) County Nevada
(b) City or town Nevada
(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 Lewis W. Shay

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, married6. (b) Name of husband or wife Judy 6. (c) Age of husband or wife if alive 45 years7. Birth date of deceased 0 Apr 1945
(Month) (Day) (Year)8. AGE: Years 82 Months 3 Days _____ If less than one day _____ hr. _____ min.9. Birthplace _____ (City, town, or county) (State or foreign country) Ill

10. Usual occupation _____

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) 9-12-45 (b) Pathyng Young
(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 Aug
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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 _____

Due to _____

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

S-28757