DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30441

FILED OCT 15 1945

Registration District No. 7 Primary Registration District No. 99-5379 Registrar's No. 60

1. PLACE OF DEATH:

(a) County DeKalb

(b) City or town Rural Sherman twp
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 3
(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).

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Gentry 38

(c) City or town Stanberry
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 1

If yes, name country

3. (a) PRINT FULL NAME Grether Ray Angle

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 Opal Fay Angle

6. (c) Age of husband or wife if alive 20 years

7. Birth date of deceased June (Month) 26 (Day) 1920 (Year)

8. AGE: Years 25 | Months 2 | Days 9 | If less than one day ... hr. ... min.

9. Birthplace Island City, Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Trucker

11. Industry or business

MOTHER FATHER

12. Name Lawrence Angle

13. Birthplace Keigley Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Betty Edson

15. Birthplace Union Star, Mo. 0
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Arthur Angle

(b) Address Stanberry, Mo

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

(c) Place: burial or cremation Hyde Ridge

18. (a) Signature of funeral director Clifford Brake

(b) Address Albany Mo

19. (a) (Date received by local registrar) (b) R.O.Swafford (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 4
year 1945 hour 6 minute 25 P. 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 accidental death — Duration

Due to was hit by a R.R. train at Highway cross

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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) accidental 32

(b) Date of occurrence Accidental

(c) Where did injury occur? on Highway DeKalb Co
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, public place?
On Highway
(Specify type of place)

While at work? (e) Means of injury

23. Signature P. S. Gale M.D. (M. D. or other)

Address U S Loon Mo Date signed 9-15-45

1539 (Licensed Embalmer's Statement on Reverse Side) Coroner DeKalb Co.

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

AUG 1 1 1948

OCT 1 9 1945

RECEIVED
District Health Officer No. 11,
District File Number
Date Filed

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 me

....., Registered Apprentice No.....

working under my personal supervision.

Signed, Christopher E. Bowler

Licensed Embalmer No. 3329

P. O. Address Albany NH

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.

S. No. 2B
M—8-21-41
I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 10 45

Registration District No. 99 Primary Registration District No. ( ) Registrar's No.

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Rural Sherman
(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 years, months or days)
In this community Like

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

3. (a) PRINT FULL NAME Arthur Ray Angle
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 June (Month) 26 (Day) 1919 (Year)

8. AGE: Years 25 | Months 2 | Days | If less than one day hr. min.

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

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation Burial Hamburg Mo

18. (a) Signature of funeral director Wood Brooks
(b) Address Albany Mo

19. (a) (Date received local registrar) (b) Roscoe Lawson (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. Day 4
year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Accidental Death	
Due to, Struck by RR. Train	
at running, Driving	
Due to Ford Truck.	
RR. Crossing on Highway	
Other conditions (Include pregnancy within 3 months of death)	

SUPPLEMENTARY INFORMATION REQUESTED

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 Sept 4 1945
(c) Where did injury occur? On RR Crossing (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? Yes (c) Means of injury

23. Signature W. S. Hale (M. D. or other)
Address Gilman Mo Date signed

30441