

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 14 1945
Registration District No. 99

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41057

State File No. _____
Registrar's No. 17

Primary Registration District No. 4168

1. PLACE OF DEATH:
(a) County DeKalb
(b) City or town Maysville
(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 50 Yrs.
years, months or days

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

4. Sex Male 5. Color or race W 6. (a) ~~Single~~ Married, ~~Never~~ M.
6. (b) Name of husband or wife Eva E. Bray 6. (c) Age of husband or wife if alive 64 years
7. Birth date of deceased March 8 1871
(Month) (Day) (Year)

8. AGE: Years 74 Months 8 Days 7 If less than one day
hr. _____ min.

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

10. Usual occupation Merchant

11. Industry or business General Merchandise

12. Name Samuel Bray
13. Birthplace So. Carolina (City, town, or county) (State or foreign country)
14. Maiden name Mary Lindley
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Eva E. Bray
(b) Address Maysville Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-18-45
(Month) (Day) (Year)

(c) Place: burial or cremation Oak Lawn Maysville

18. (a) Signature of funeral director Palcher Funeral Home

(b) Address Maysville Mo

19. (a) 11-17-45 (Date received locally) (b) Rosa Duvall (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County DeKalb 32
(c) City or town Maysville 2
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) 0
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 15
year 1945 hour 8 minute 45 P.M.

21. I hereby certify that I attended the deceased from 7-12 to 7-15-45
that I last saw him alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 3 mo
(Hemiplegia) Arterio Sclerosis 10 3/4
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? _____ (c) Means of injury 2

23. Signature R. R. Reynolds (M. D. or other) do.
Address Maysville Mo Date signed 11-18-45

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

DISTRICT HEALTH OFFICE
Cameron, Mo.

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.....

Licensed Embalmer No.....

3960

W. H. Russell 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.