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X32873

FILED FEB 7 1946

Registration District No. **127**

Primary Registration District No. **5464**

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

1. PLACE OF DEATH:

(a) County **Greene**
 (b) City or town **Willard**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
At the Family Home
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community **40 years or more**
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Greene**
 (c) City or town **Willard**
(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 **Hubert Henry Bray**
FULL NAME

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 **Mrs Viva Bray** 6. (c) Age of husband or wife if alive **28** years
 7. Birth date of deceased **November 28 1885**
(Month) (Day) (Year)

8. AGE: Years **60** Months **1** Days **27** If less than one day
hr. min.

9. Birthplace **Greene County, Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired Railroad man**

11. Industry or business

MOTHER FATHER { 12. Name **Thomas Henry Bray**
 13. Birthplace **Indiana**
(City, town, or county) (State or foreign country)
 14. Maiden name **Ida Mae Forrester**
 15. Birthplace **Strafford, Missouri**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Hubert H. Bray**
 (b) Address **Willard, Missouri**

17. (a) **burial** (b) Date thereof **January 27**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **MT. PLEASANT**

18. (a) Signature of funeral director **R. L. Greenwade Und Co**
 (b) Address **Willard, Missouri**

19. (a) **Jan 26 46** (b) **Jane Appleby**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **January** day **25th**
 year **1946** hour **11** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Jan 22**
1946 to **Jan 25** 19**46**
 that I last saw him alive on **Jan 25** 19**46**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Ashtma - continuous for 2 1/2 years**
 Due to **cause unknown**

Due to _____
 Other conditions **Suspected Lung Tumor**
(Include pregnancy within 6 months of death)

Major findings: **FID**
 Of operations _____
 Of autopsy **Left leg removed for gangrene - 8 years ago**

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? _____ (i) Means of injury _____
 23. Signature **D. Charles H. ...** (M. D. or other) **M.D.**
 Address **1st Grove, Mt** Date signed **1-26-46**

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

Greene County Health Office,

County File Number 46-2-12

Date Filed 2-4-46

FEB 23 1946

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 Mrs. E. W. Greenwood

Licensed Embalmer No. 2095

P. O. Address Willard, Missouri

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. Feb
Registrar's No. 1

Registration District No. 127

Primary Registration District No. 5464

1. PLACE OF DEATH:
 (a) County Greene
 (b) City or town Willard
 (If outside city or town limits, write "RURAL" and name of township) Murray Twp
 (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 _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME: Hubert 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 m 28 1946
 (Month) (Day) (Year)

8. AGE: Years 60 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

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. (c) _____ (b) Date thereof _____ (Month) (Day) (Year)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) Jane Appleby
 (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 _____ year 1946 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 _____

SUPPLEMENTARY

Duration _____
PHYSICIAN
 Underline the cause to which death should be charged statistically.

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

596

2672