S. No. 2
DM—5-43
v. 5-17-39
I X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 17 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 13254

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1573

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

1. PLACE OF DEATH:

(a) County Jackson

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

(c) Name of hospital or institution:
Vineyard Park Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 8 hrs (Specify whether
In this community 7 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson 48

(c) City or town Kansas City 3
(If outside city or town limits, write "RURAL")

(d) Street No. 1030 Monroe 8
(If rural, give location) 0

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

If yes, name country

3. (a) PRINT FULL NAME William Thomas Mc Cray

3. (b) If veteran, name war No

3. (c) Social Security No. 509-10-5273

4. Sex Male 0

5. Color or race Wh

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

6. (b) Name of husband or wife ~~Bxkk~~ Breeta Johnson McGray

6. (c) Age of husband or wife if alive 39 years

7. Birth date of deceased 2/2/1901 (Month) (Day) (Year)

8. AGE: Years 45 Months 1 Days 29 If less than one day hr. min.

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

10. Usual occupation Pump operator

11. Industry or business City of Kansas City

FATHER
12. Name William Thomas Mc Cray
13. Birthplace Glensted, Mo. 0 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Lillian Bell Carr
15. Birthplace Mo. 0 (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Breeta Mc Cray

(b) Address 1030 Monroe

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/3/46 (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Washington

18. (a) Signature of funeral director John P. Sheil

(b) Address Kansas City, Mo.

19. (a) 4-2-46 (Date received local registrar) (b) Geraldine Holmes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month apr day 1 year 1946 hour 2 minute P M.

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

Immediate cause of death Ruptured Gastric Ulcer

Due to Intra Intestinal Hemorrhage

Due to

Other conditions (Include pregnancy within 3 months of death) 117a

Major findings:
Of operations

Of autopsy yes — as above

Duration

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 3 Gun

23. Signature [signature] (M. D. ~~or other~~)

Address 1424 Of Pry Date signed 4-2-46

(Licensed Embalmer's Statement on Reverse Side)

William Thomas McCray
1030 Monroe
Age 45
Height 5'11"
Black Hair
Black eyes

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 John P. Shell

Licensed Embalmer No. 3625

P. O. Address K. C. 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.