

No. 2  
12-45  
5-17-39  
PI X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED NOV 20 1947

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 37464  
Registrar's No. 63

Registration District No. 23 Primary Registration District No. 4133

1. PLACE OF DEATH:  
(a) County Clay  
(b) City or town Kearney  
(c) Name of hospital or institution:  
(If outside city or town limits, write "RURAL" and name of township)  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1  
In this community 1  
years, months or days (Specify whether)

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County Clay  
(c) City or town Kearney Mo  
(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 Lillie Leona Graves  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. none

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Sept day 28<sup>th</sup>  
year 1947 hour 10:00 minute \_\_\_\_\_ 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.

4. Sex Female 5. Color or race white  
6. (a) Single, widowed, married, divorced Widowed  
6. (b) Name of husband or wife Montgomery  
6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased: September 3rd 1864  
(Month) (Day) (Year)

Immediate cause of death Coronary Occlusion Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

8. AGE: Years 83 Months \_\_\_\_\_ Days 25 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Jonithon Perry Bryan

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

14. Maiden name Mary A. Fourn

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

16. (a) Informant Linn E. Bryan

(b) Address 4575 Eichetberg St St Louis Mo

17. (a) Burial (b) Date thereof Oct 1 1947  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt. Olivet Cem Kearney

18. (a) Signature of funeral director Leonard Fry  
(b) Address Kearney Mo

19. (a) Sept 30-47 Missouri Haynes  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Coronary Occlusion  
(b) Date of occurrence 9-28-47  
(c) Where did injury occur? Kearney Clay Mo  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
Home (Specify type of place) \_\_\_\_\_  
While at work? \_\_\_\_\_ (e) Means of injury 3  
23. Signature R. W. Cradler (M. D. or other) \_\_\_\_\_  
Address Excelsior Springs Mo Date signed 9-29-47

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

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

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 11-19-47

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 Leonard Fry

Licensed Embalmer No. 1677

P. O. Address Kearney 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.