

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

State File No. **654**
Registrar's No. **5**

FILED FEB 14 1949

BIRTH NO. _____ REG. DIST. NO. **75** PRIMARY REG. DIST. NO. **5300**

1. PLACE OF DEATH a. COUNTY Clinton		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY DeKalb	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Platte Twp		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Rural Polk Twp.	
c. LENGTH OF STAY (in this place) 4 mo		d. STREET ADDRESS (If rural, give location) 1	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1			

3. NAME OF DECEASED (Type or Print) William T. Gray	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year) 1 31 49
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 1-9-1870	9. AGE (In years last birthday) (Months) (Days) (Hours) (Min.) 79 0 25
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Clinton Co. Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Jefferson Gray	13b. MOTHER'S MAIDEN NAME Virginia Blue	14. NAME OF HUSBAND OR WIFE Mrs. Sarah Gray
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. X X	17. INFORMANT'S SIGNATURE OR NAME Mrs. Sarah Gray Osborn, MD	ADDRESS Osborn, MO
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis		INTERVAL BETWEEN ONSET AND DEATH unkn
	ANTECEDENT CAUSES Aforbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS * Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION 4	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **4-1, 1948**, to **1-25, 1949**, that I last saw the deceased alive on **1-25, 1949**, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Harold Lewis MD	23b. ADDRESS Osborn, Mo	23c. DATE SIGNED 2-1-49
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24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	24b. DATE 1-2-49	24c. NAME OF CEMETERY OR CREMATORY PERRIN	24d. LOCATION (City, town, or county) (State) PERRIN MISSOURI
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DATE REC'D BY LOCAL REG. 2-5-49	REGISTRAR'S SIGNATURE Winifred W. Moser	390	25. FUNERAL DIRECTOR'S SIGNATURE D. D. Lyon	ADDRESS Plattsburg MO.
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No. 300
10-48

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

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 _____

working under my personal supervision.

Student
Student Embalmer

Student Embalmer No. _____

Signed Donell D. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg, MD

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.