

No. 300
10.48

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Dr. Youll
234 1/2 E Commercial
State File No. 998

FILED JAN 16 1949

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY Greene		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Greene	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Springfield	
c. LENGTH OF STAY (in this place) Life		d. STREET ADDRESS (If rural, give location) 2147 Boonville	
d. FULL NAME OF HOSPITAL OR INSTITUTION 2147 Boonville			

3. NAME OF DECEASED (Type or Print) Mae Stapp Wray			4. DATE OF DEATH (Month) (Day) (Year) Jan. 8 1949		
a. (First)		b. (Middle)	c. (Last)		

5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH June 21 1899	9. AGE (In years last birthday) 49	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours	IF UNDER 24 HRS. Min.
------------------	---------------------------	--	----------------------------------	---------------------------------------	---------------------------	--------------------------	---------------------------	--------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Niangua, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
--	-----------------------------------	--	--

13a. FATHER'S NAME Thomas G. Winn	13b. MOTHER'S MAIDEN NAME Rillia Terry	14. NAME OF HUSBAND OR WIFE Eugene M. Wray
--------------------------------------	---	---

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. No	17. INFORMANT'S SIGNATURE OR NAME Eugene Wray	ADDRESS Springfield, Mo.
--	-------------------------------	--	-----------------------------

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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <i>Cerebral Hemorrhage</i>		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <i>Hypertensive Cerebro-</i> DUE TO (c) <i>Vascular Renal disease</i>		
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	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	---

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)
--	--	---

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? 2
--	--	---------------------------------

22. I hereby certify that I attended the deceased from 1945 to 1949, to Jan 8, 1949, that I last saw the deceased alive in Nov, 1948, and that death occurred at 2:30 Am., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Dr. D. F. Youll, D.O.	23b. ADDRESS 234 1/2 E Commercial	23c. DATE SIGNED 1-10-49
---	--------------------------------------	-----------------------------

24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 1/12/49	24c. NAME OF CEMETERY OR CREMATORY Eastlawn	24d. LOCATION (City, town, or county) (State) Springfield, Mo.
---	----------------------	--	---

DATE REC'D BY LOCAL REG. 1-11-49	REGISTRAR'S SIGNATURE W.S. Handley	25. FUNERAL DIRECTOR'S SIGNATURE H.H. Lohmeyer	ADDRESS Springfield, Mo.
-------------------------------------	---------------------------------------	---	-----------------------------

(Licensed Embalmer's Statement on Reverse Side)

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

39-26

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.....

..... Student Embalmer No.

working under my personal supervision.

Signed *Walter E. Hamilton*.....

Signed.....
Student Embalmer

Licensed Embalmer No. *3868*.....

P. O. Address *Springfield, Ma.*.....

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.