

FILED JUN 16 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **20353**

BIRTH NO. _____ REG. DIST. NO. **238** PRIMARY REG. DIST. NO. **5823** Registrar's No. **24**

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY: New Madrid | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE: Missouri b. COUNTY: New Madrid | |
| b. CITY OR TOWN: New Madrid (Royal) | | c. CITY OR TOWN: New Madrid, Mo. | |
| c. LENGTH OF STAY (in this place): 6 wks | | d. STREET ADDRESS (If rural, give location): 5 Miles North | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION: NONE | | | |

| | | | | | | | | | | | |
|---|--|----------------------------|-----------------------------------|--|--|--|--|--|--|--|--|
| 3. NAME OF DECEASED (Type or Print) WAITER | | a. (First) | | b. (Middle) | | c. (Last) McRAY Jr. | | 4. DATE OF DEATH (Month) (Day) (Year) May 29, 1949 | | | |
| 5. SEX: M | | 6. COLOR OR RACE: C | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married | | 8. DATE OF BIRTH: May 24, 1949 | | 9. AGE (In years) (If under 1 year last birthday) (Months) (Days) (Hours) (Min.): 5 5 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired): Factory | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | 11. BIRTHPLACE (State or foreign country): New Madrid (Royal) | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |

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|---|--|--|--|--|--|
| 13a. FATHER'S NAME: WAITER McRAY | | 13b. MOTHER'S MAIDEN NAME: Angeline Gaddy | | 14. NAME OF HUSBAND OR WIFE: NONE | |
| 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.: NONE | | 17. INFORMANT'S SIGNATURE OR NAME: Walter McRay | |
| | | | | ADDRESS: New Madrid, Mo. | |

| | | | | | | | |
|--|--|---|--|--|--|----------------------------------|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia (Bronchis) | | | | | |
| | | ANTECEDENT CAUSES | | | | | |
| | | Morbid conditions, if any, giving rise to the above cause: (a) stating the underlying cause last. DUE TO (b) Atelectasis | | | | | |
| | | DUE TO (c) | | | | | |
| | | II. OTHER SIGNIFICANT CONDITIONS | | | | | |
| | | Conditions contributing to the death but not related to the disease or condition causing death. | | | | 7620 | |

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input 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) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |

22- I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at **12:50 P.M.**, from the causes and on the date stated above.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 23a. SIGNATURE: OR Charles M. D. Jones | | (Degree or title) | | 23b. ADDRESS: 478 1/2 Main St. New Madrid, Mo. | | 23c. DATE SIGNED: 6/1/49 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify): Burial | | 24b. DATE: May 30, 1949 | | 24c. NAME OF CEMETERY OR CREMATORY: Grand Hill Cemetery, New Madrid, Mo. | | 24d. LOCATION (City, town, or county) (State): Mo. | |
| DATE REC'D BY LOCAL REG.: 8-49 | | REGISTRAR'S SIGNATURE: Helen Lou Jones | | 25. FUNERAL DIRECTOR'S SIGNATURE: Friends | | ADDRESS | |

(Licensed Embalmer's Statement on Reverse Side)

No. 300
10.48

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

RECEIVED

District Health Office No. 2

District File Number 649-663

Date Filed 6-10-49

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 _____

Not Embalmed

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.