

FILED JAN 30 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 809

BIRTH NO. _____ REG. DIST. NO. 128 PRIMARY REG. DIST. NO. 2000 Registrar's No. 84

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE ARKANSAS b. COUNTY BAXTER	
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 GAMAUDEL 8030	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 681 S. ROBERTSON		d. STREET ADDRESS (If rural, give location) 8	
3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) FRANKLIN c. (Last) GRAYHAM			4. DATE OF DEATH (Month) (Day) (Year) JAN. 27 1950
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 16, 1872
10a. USUAL OCCUPATION (Give kind of work describing most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARM	9. AGE (In years last birthday) 77
11. BIRTHPLACE (State or foreign country) TENNESSEE		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME JOHN WILLIAMS		13b. MOTHER'S MAIDEN NAME FRONNIE PRINCE	14. NAME OF HUSBAND OR WIFE UNKNOWN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) UNKNOWN		16. SOCIAL SECURITY NO. NO	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Clara Bentley 681 S. Robertson
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH: Carcinoma of the rectum ANTECEDENT CAUSES Morbid 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. 154X	
19a. DATE OF OPERATION None		19b. MAJOR FINDINGS OF OPERATION None	
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) _____ m. _____		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 27 Nov, 1949, to 30 Nov, 1949, that I last saw the deceased alive on 30 Nov, 1949, and that death occurred at 10:30 a.m., from the causes and on the date stated above.			
23a. SIGNATURE William W. Wood (Degree or title) M.D.		23b. ADDRESS 500 Holland Bldg.	
23c. DATE SIGNED 1/27/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		24b. DATE 1-29-50	
24c. NAME OF CEMETERY OR CREMATORY GAMAUDEL Cem.		24d. LOCATION (City, town, or county) (State) GAMAUDEL, ARK.	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE 1-28-50 W. Handley M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Rollin Barber, Mt. Home	

(Licensed Embalmer's Statement on Reverse Side)

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

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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 John M. Davies.....

Signed.....
Student Embalmer

Licensed Embalmer No.....

P. O. Address Intar Home Care.....

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.