

FILED MAY 18 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 15876

BIRTH NO. _____ REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 5122 Registrar's No. 150

1. PLACE OF DEATH
a. COUNTY Boone

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Missouri b. COUNTY Boone

b. CITY OR TOWN Hallsville c. LENGTH OF STAY (In this place) _____

c. CITY OR TOWN Hallsville d. STREET ADDRESS (If rural, give location) Route 2

d. FULL NAME OF HOSPITAL OR INSTITUTION Rocky x Fork Township

3. NAME OF DECEASED
a. (First) Maggie b. (Middle) MAY c. (Last) Gray

4. DATE OF DEATH (Month) (Day) (Year) May 9 1950

5. SEX F **6. COLOR OR RACE** W **7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)** Married

8. DATE OF BIRTH Feb 26 1891 **9. AGE** (In years) (Months) (Days) 59 2 13

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Housewife **11. BIRTHPLACE** (State or foreign country) Howard Co Mo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME T. D. Elder **13b. MOTHER'S MAIDEN NAME** Hettie M. Mc Kinzie **14. NAME OF HUSBAND OR WIFE** Charles Gray

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. 40 **17. INFORMANT'S SIGNATURE OR NAME** Charles Gray **ADDRESS** Hallsville MO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute cardiac decompensation?

ANTECEDENT CAUSES
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.

DUE TO (b) Maxine cardiac hypertrophy
DUE TO (c) chronic valvular endocarditis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis
chronic parasympathetic

19a. DATE OF OPERATION _____ **19b. MAJOR FINDINGS OF OPERATION** replete

20. AUTOPSY? YES NO

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 NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? renewed aneurysm 4219

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 9 A.M., from the causes and on the date stated above.

23a. SIGNATURE Harry G. Coffey (Degree or title) M.D. **23b. ADDRESS** Columbia Mo **23c. DATE SIGNED** 5-10-50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** May 11 1950 **24c. NAME OF CEMETERY OR CREMATORY** Memorial Park **24d. LOCATION** (City, town, or county) (State) Columbia Mo

DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE May 11 1950 Mrs R. G. Palmer **31** **25. FUNERAL DIRECTOR'S SIGNATURE** POURVOIR **ADDRESS** Columbia Mo

RECEIVED
MAY 15 1950
District Health Officer No. 9,
District File Number

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, by

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Ernest H. Spunkle

Licensed Embalmer No. 4013

P. O. Address Columbus, 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.