

No. 300 FILED APR 29 1952  
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THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **11894**

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **4** PRIMARY REG. DIST. NO. **4014** Registrar's No. **30**

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

1. PLACE OF DEATH a. COUNTY <b>Atchison Co</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Mo</b> b. COUNTY <b>Atchison</b>	
b. CITY OR TOWN <b>Fairfax</b>		c. CITY OR TOWN <b>Rock - Part Mo</b>	
c. LENGTH OF STAY (in this place) <b>6 days</b>		d. STREET ADDRESS (If rural, give location) <b>4 miles N.E. of Rock Part</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Fairfax Hospital</b>			

3. NAME OF DECEASED (Type or Print) a. (First) <b>Emily</b>	b. (Middle)	c. (Last) <b>Bray</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>April 14 - 1952</b>
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>married</b>	8. DATE OF BIRTH <b>Mar-26/1888</b>	9. AGE (In years last birthday) <b>64</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>18</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Cornwall, England</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>Arthur Cleave</b>	13b. MOTHER'S MAREN NAME <b>Emily Davis</b>	14. NAME OF HUSBAND OR WIFE <b>Don Bray Rock Part Mo</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>no</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Don Bray</b>	ADDRESS <b>Rock - Part Mo</b>
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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, ashenia, 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) <b>meningitis, acute</b>		<b>2 days</b>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>parotid gland infection</b>		<b>3 days</b>
DUE TO (c) <b>Pneumonia, virus type</b>		<b>4 days</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Coronary thrombosis acute</b>		<b>6 days</b>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>none</b>	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) <b>492X</b>
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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?
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22. I hereby certify that I attended the deceased from **1947**, to **Apr 14**, 1952, that I last saw the deceased alive on **Apr 13**, 1952, and that death occurred at **7:45 A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Emmanuel B. Deane M.D.</b>	23b. ADDRESS <b>Rock Part Mo</b>	23c. DATE SIGNED <b>Apr 15 1952</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	24b. DATE <b>Apr. 16-1952</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Smith Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>Rock - Part Mo</b>
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DATE REC'D BY LOCAL REG. <b>April 24, 1952</b>	REGISTRAR'S SIGNATURE <b>Marvin N. Schuler</b>	443-0	25. FUNERAL DIRECTOR'S SIGNATURE <b>E. E. Benton</b>	ADDRESS <b>Rock Part Mo</b>
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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 \_\_\_\_\_

*C. E. Burton*

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed *C. E. Burton* \_\_\_\_\_

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. *1264*

P. O. Address *Boeh Post No*

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.