

STANDARD CERTIFICATE OF DEATH

8411

State File No.

LED MAR 6 - 1953

BIRTH NO.

REG. DIST. NO. 332PRIMARY REG. DIST. NO. 3074Registrar's No. 35

| | | | | | | | | | | | |
|--|-------------------------------|---|---|---|---|---|--------------------------------------|---|---------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Scott</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>New Madrid</u> | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Sikeston</u> | | c. LENGTH OF STAY (in this place) hours <u>0</u> | | c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Canalou</u> <u>0920</u> | | d. STREET ADDRESS (If rural, give location) <u>1</u> | | | | | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Mo. Delta Community Hosp</u> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) a. (First) <u>Thomas</u> b. (Middle) <u>Franklin</u> c. (Last) <u>Gray</u> | | | 4. DATE OF DEATH (Month) <u>2</u> (Day) <u>24</u> (Year) <u>1953</u> | | | | | | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced 3</u> | | 8. DATE OF BIRTH <u>1-15-1880</u> | | 9. AGE (In years last birthday) <u>73</u> | IF UNDER 1 YEAR Months | IF UNDER 1 YEAR 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) <u>Retired</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u> | | 11. BIRTHPLACE (State or foreign country) <u>Gray Ridge, Missouri</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13a. FATHER'S NAME <u>William Gray</u> | | | 13b. MOTHER'S MAIDEN NAME <u>Mary Manley</u> | | | 14. NAME OF HUSBAND OR WIFE <u>Alice Gray</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Ferrell Gray - Keokuk Ky</u> | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | | | |
| 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, asthma, etc. It means the disease, injury, or complication which caused death. | | | | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Myocardial infarction</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u> | |
| ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. | | | | DUE TO (b) <u>Coronary insufficiency</u> | | | | | | | |
| DUE TO (c) <u>Other diseases</u> | | | | | | | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | | <u>Pulmonary Edema</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION <u>4201</u> | | | | | | | | 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.) <u>Sikeston</u> | | | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Sikeston SCOTT Mo.</u> | | | | | | |
| 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? | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>12:30 PM, 1953</u> , to <u>24 Feb, 1953</u> , that I last saw the deceased alive on <u>6:30 PM, 1953</u> , and that death occurred at <u>6:47 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) <u>Audra B. Smith M.D.</u> | | | | 23b. ADDRESS <u>Sikeston Mo.</u> | | | 23c. DATE SIGNED <u>25 Feb 53</u> | | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 24b. DATE <u>2-26-53</u> | 24c. NAME OF CEMETERY OR CREMATORY <u>IOALIA</u> | | 24d. LOCATION (City, town, or county) (State) <u>IOALIA MO</u> | | | | | | |
| DATE REC'D BY LOCAL REG. <u>2-26-53</u> | | REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter 421</u> | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Welsh Funeral Home Sikeston Mo</u> | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

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

203

Mitten

MAR 2 1953

RECEIVED
SCOTT COUNTY HEALTH CENTER

CO. FILE NO. 353-58

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 _____

working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed Raymond Crews

Licensed Embalmer No. 3467

P. O. Address Sikeston 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.