

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

24299

State File No. _____

FILED AUG 4 - 1953

BIRTH NO. _____ REG. DIST. NO. **93** PRIMARY REG. DIST. NO. **4156** Registrar's No. **53-74**

1. PLACE OF DEATH a. COUNTY Dade		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo b. COUNTY Dade	
b. CITY (If outside corporate limits, write RURAL and give town or township) So. Greenfield Mo		c. CITY (If outside corporate limits, write RURAL and give township) 0290 OR TOWN So. Greenfield Mo 0	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location)	
d. FULL NAME OF HOSPITAL OR INSTITUTION home			

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) Bertha	b. (Middle) Alice	c. (Last) Wray	(Month) July	(Day) 27	(Year) 1953
5. SEX F	6. COLOR OR RACE W	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed	8. DATE OF BIRTH Aug. 18, 1887	9. AGE (In years last birthday) 65	IF UNDER 1 YEAR Months 11 Days 9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY house wife	11. BIRTHPLACE (State or foreign country) Dade Co Mo. 0		12. CITIZEN OF WHAT COUNTRY? usa

13a. FATHER'S NAME Francis T Phillips	13b. MOTHER'S MAIDEN NAME Sarah A Draughon	14. NAME OF HUSBAND OR WIFE E.A. Wray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. none	17. INFORMANT'S SIGNATURE OR NAME Frank Phillips ADDRESS Greenfield Mo.

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* apoplexy		
	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.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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) 334X
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 6-1, 1953, to 7-27, 1953, that I last saw the deceased alive on 7-25, 1953, and that death occurred at 3:00p. m., from the causes and on the date stated above.

23a. SIGNATURE <i>W. C. Canada</i> (Degree or title)	23b. ADDRESS Greenfield Mo	23c. DATE SIGNED 7-28-53
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 7-29-53	24c. NAME OF CEMETERY OR CREMATORY Greenfield
24d. LOCATION (City, town, or county) Greenfield Mo		(State) _____

DATE REC'D BY LOCAL REG. 7-29-53	REGISTRAR'S SIGNATURE <i>J. C. Canada</i> 477-0	25. FUNERAL DIRECTOR'S SIGNATURE W.R. Allison ADDRESS Greenfield Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

No. 300
0.48

290

AUG 5

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.

Student
Student Embalmer

Signed *W. R. Allison*

Licensed Embalmer No. *4404*

P. O. Address *Greenfield, MA*

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.