

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **43196**

FILED JAN 4 - 1956

360

3076

Registrar's No. **199**

|  |                            |  |  |   |  |  |   |   |
|--|----------------------------|--|--|---|--|--|---|---|
| BIRTH NO. _____  |                            | REG. DIST. NO. _____   |  | PRIMARY REG. DIST. NO. _____  |  | Registrar's No. <b>199</b>   |   |   |
| 1. PLACE OF DEATH<br>a. COUNTY <b>Vernon</b>   |                            |  |  | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>Missouri</b> b. COUNTY <b>Bates</b>   |  |  |   |   |
| b. CITY (If outside corporate limits, write RURAL and give town) <b>Nevada</b>   |                            | c. LENGTH OF STAY (In this place)  |  | c. CITY OR TOWN <b>Foster</b>   |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |   |   |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>507 South Cedar</b>   |                            |  |  | e. STREET ADDRESS (If rural, give location) <b>9077</b>   |  |  |   |   |
| 3. NAME OF DECEASED<br>a. (First) <b>Arthur</b>  |                            |  | b. (Middle) <b>Bradley</b>                               |   | c. (Last) <b>Gray</b>  |  | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>November 28, 1955</b> |   |
| 5. SEX <b>M</b>  | 6. COLOR OR RACE <b>Wh</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>                                  |  | 8. DATE OF BIRTH <b>October 11, 1871</b>  |  | 9. AGE (In years last birthday) <b>84</b>  | IF UNDER 1 YEAR<br>Months _____ Days _____                        |   |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>   |                            | 10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>   |  | 11. BIRTHPLACE (City and State or Foreign Country) <b>Homer Illinois</b>  |  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |   |   |
| 13a. FATHER'S NAME <b>Matthew Gray</b>   |                            |  | 13b. MOTHER'S MAIDEN NAME <b>McLaughlin</b>              |   | 14. NAME OF HUSBAND OR WIFE <b>Annie Wilson Gray</b>                 |  |   |   |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |                            | 16. SOCIAL SECURITY NO. <b>None</b>  |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Mae G. Steffan Bettendorf, Iowa</b>   |  |  |   |   |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.                                  |                            |  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Atherosclerotic CUR Disease</b><br>DUE TO (c) _____<br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>442x</b> |  |  |   | INTERVAL BETWEEN ONSET AND DEATH<br><b>56 hrs</b> |
| 19a. DATE OF OPERATION   |                            | 19b. MAJOR FINDINGS OF OPERATION   |  |   |  | 20. AUTOPSY?<br>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)  |                            | 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 <b>9:29</b> , <b>1955</b> , to <b>Nov 28, 1955</b> , that I last saw the deceased alive on <b>Nov. 28, 1955</b> , and that death occurred at <b>5:25 pm</b> from the causes and on the date stated above. |                            |  |  |   |  |  |   |   |
| 23a. SIGNATURE <b>M. Steffan</b> (Degree or title)   |                            |  |  | 23b. ADDRESS <b>Nevada Mo</b>   |  | 23c. DATE SIGNED <b>11/30/55</b>   |   |   |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |                            | 24b. DATE <b>December 1, 1955</b>  | 24c. NAME OF CEMETERY OR CREMATORY <b>Salem Cemetery</b> |   | 24d. LOCATION (City, town, or county) (State) <b>Foster Missouri</b> |  |   |   |
| DATE REC'D BY LOCAL REG. <b>12-28-55</b>   |                            | REGISTRAR'S SIGNATURE <b>Anna J. Ferry</b> <b>451</b>  |  | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS<br><b>Ferry Funeral Home Nevada, Mo.</b>   |  |  |   |   |

(Licensed Embalmer's Statement on Reverse Side)

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

300  
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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..

Student.....  
Signature of Student Embalmer

Signed..... *L. Anglin Ferry* .....

Licensed Embalmer No. *49*.....

P. O. Address... Nevada, I.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.