

FILED APR 18 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12658

State File No.

BIRTH NO. 124 REG. DIST. NO. 68 PRIMARY REG. DIST. NO. 5267 Registrar's No. 13

1. PLACE OF DEATH a. COUNTY <u>Christian Co</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> COUNTY <u>Christian</u>	
b. CITY (If outside corporate limits, write RURAL and give town) <u>Rural. S Galloway</u>		c. CITY OR TOWN <u>Spokane Mo</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. LENGTH OF STAY (in this place) <u>4 yrs</u>		e. STREET ADDRESS <u>Spokane Mo</u>	02280
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Spokane Mo</u>			

3. NAME OF DECEASED (Type or Print) a. (First) <u>Ida</u>	b. (Middle)	c. (Last) <u>Gray</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>April 7-1956</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>8-14-1872</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Mo</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Jacob M Cummings</u>	13b. MOTHER'S MAIDEN NAME <u>Mary Brown</u>	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>Jacob H Gray, Spokane Mo</u>	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>4 years</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute Circulatory Failure</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.		DUE TO (b) <u>Coronary Arteriosclerosis</u>	
		DUE TO (c) <u>Myocardial infarction</u>	
		<u>Arteriosclerosis</u>	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 10/23, 1953, to 1/14, 1956, that I last saw the deceased alive on 1/14, 1956, and that death occurred at m., from the cause and on the date stated above.

23a. SIGNATURE <u>Concent R. McCormick D.O.</u> (Degree of title)	23b. ADDRESS <u>Osark Mo.</u>	23c. DATE SIGNED <u>4/14/56</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>4-9-1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Chestnutridge</u>	24d. LOCATION (City, town, or county) (State) <u>Christian Co., Mo</u>
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DATE REC'D BY LOCAL REG <u>Apr. 16-1956</u>	REGISTRAR'S SIGNATURE <u>Luella Leonard</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>T. B. Chaffin Osark Mo</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

590

1972 20 1950

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 *T. B. Chaffin*.....

Licensed Embalmer No. *219*.....

P. O. Address *Ozark*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.