

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **21449**

FILED JUN 18 1956

BIRTH NO. _____		REG. DIST. NO. <u>224</u>		PRIMARY REG. DIST. NO. <u>3052</u>		Registrar's No. <u>238</u>			
1. PLACE OF DEATH a. COUNTY <u>PETTIS</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>MORGAN</u>					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>SEDALIA</u>		c. LENGTH OF STAY (In this place) <u>1 WEEK</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>STOVER</u>		d. STREET ADDRESS (If rural, give location) <u>STOVER Mo.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Ros - new addition to Sedalia</u>									
3. NAME OF DECEASED (Type or Print) a. (First) <u>MARY</u> b. (Middle) <u>THERESA</u> c. (Last) <u>WRAY</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JUNE 11 1956</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>DEC. 23 1876</u>			
9. AGE (In years) <u>80</u> 10. MONTHS <u>5</u> 11. DAYS <u>18</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13a. FATHER'S NAME <u>CHARLES THOUVENET</u>		13b. MOTHER'S MAIDEN NAME <u>AMANDA LEONARD</u>			
14. NAME OF HUSBAND OR WIFE <u>JOSEPH WRAY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT'S SIGNATURE OR NAME <u>JOSEPH WRAY</u> ADDRESS <u>STOVER MO</u>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>CORONARY OCCLUSION</u> ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES ☐ NO ☒		4201			
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>STOVER, 1956</u> to <u>DECEASED, 1956</u> , that I last saw the deceased alive on <u>JUNE 8, 1956</u> , and that death occurred at <u>2:23 p.m.</u> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <u>Dr. J. H. Stevenson</u>		23b. ADDRESS <u>SEDALIA, MO.</u>		23c. DATE SIGNED <u>JUNE 13 1956</u>					
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>JUNE 14 1956</u>		24c. NAME OF CEMETERY OR CREMATORY <u>PLEASANT UNION</u>		24d. LOCATION (City, town, or county) (State) <u>MORGAN COUNTY MO</u>			
DATE REC'D BY LOCAL REG. <u>6-13-56</u>		REGISTRAR'S SIGNATURE <u>J. H. Stevenson Deputy</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. H. Stevenson</u> ADDRESS <u>Stover Mo</u>					

(Licensed Embalmer's Statement on Reverse Side)

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

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
Student Embalmer

Signed J. L. Stevenson
Student Embalmer No. _____
Licensed Embalmer No. 4073
P. O. Address Stover 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.