

Health, & Welfare
Public Health Service
S. 000
1-57
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

FILED OCT 22 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37056

STATE FILE NUMBER

Registration District No. 314 Primary Registration District No. 4457 Registrar's No. 58

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

| | | | | | |
|--|-------------------------------|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>ST. CLAIR</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>ST. CLAIR</u> | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>LOWRY CITY</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | c. CITY OR TOWN <u>LOWRY CITY</u> | | Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N. JACKSON TWP</u> | | Length of stay in 1b <u>years</u> | d. STREET ADDRESS (If outside, give location) <u>N. JACKSON TWP</u> | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>CALVIN</u> Middle <u>O</u> Last <u>BRAY</u> | | | 4. DATE OF DEATH Month <u>OCT</u> Day <u>12</u> Year <u>1957</u> | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 27, 1866</u> | 9. AGE (In years last birthday) <u>91</u> | 10. FUNDER 1 YEAR Months <u>7</u> Days <u>1</u> Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, except if retired) <u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) <u>INDIANA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> |
| 13a. FATHER'S NAME <u>J. H. BRAY</u> | | 13b. MOTHER'S MAIDEN NAME <u>SARAH HANCOCK</u> | | 14. NAME OF HUSBAND OR WIFE <u>deceased</u> | |
| 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. <u>NONE</u> | 17. INFORMANT Address <u>ROY BRAY LOWRY CITY MO</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asthenia</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>senility</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>794X</u> | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | | |
| 20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____ | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | | 20f. CITY, TOWN, OR LOCATION COUNTY STATE <u>Personal knowledge no record</u> | |
| 21. I attended the deceased from _____ to _____ and last saw him alive on _____ months ago. Death occurred at <u>7:00 a.m.</u> on the date stated above; and to the best of my knowledge, from the causes stated. | | | | | |
| 22a. SIGNATURE <u>Ruth Seewer MD</u> (Degree or title) | | | 22b. ADDRESS <u>OSCEOLA MO</u> | | 22c. DATE SIGNED <u>10-13-57</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE <u>10-13-57</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>ICANIUM</u> | | 23d. LOCATION (City, town, or county) (State) <u>ICANIUM MO</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>Goodrich & HOME OSCEOLA MO</u> | | | 25. DATE RECD. BY LOCAL REG. <u>10-18-57</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Seewer</u> | |

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 *J. B. [Signature]*

Licensed Embalmer No. *3038*

P. O. Address *Osceola W*

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.