

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-031251

FILED VS AUG 26 1959

Registration District No. 354 Primary Registration District No. 6197 Registrar's No. 21

STATE FILE NUMBER

NDED

1. PLACE OF DEATH a. COUNTY <u>Texas</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Texas</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Burdino twp.</u>		Length of stay in lb <u>33 yrs.</u>	c. CITY OR TOWN <u>Cabool</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>3 mi. South of Cabool</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Rt. 3</u>		Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Olivia</u> Last <u>Gray</u>			4. DATE OF DEATH Month <u>8</u> Day <u>6</u> Year <u>1959</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>7-2-1889</u>	9. AGE (last birthday) <u>70</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) <u>Witt, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>Henry T. Whitneck</u>		13b. MOTHER'S MAIDEN NAME <u>Mary L. Ash</u>		14. NAME OF HUSBAND OR WIFE <u>James Gray</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.	17. INFORMANT Address <u>Walter Gray, Cabool, 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>crushed skull</u> DUE TO (b) <u>falling from auto.</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>was brief</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Multiple fractures</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input checked="" 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.) <u>Fell out of Automobile and was pinned under it AS</u>			
20c. TIME OF INJURY Hour <u>11:45</u> -a.m. Month, Day, Year <u>8-6-1959</u>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Country Road</u>					
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20f. CITY, TOWN, OR LOCATION <u>Burdino twp., 3 mi. South of Cabool</u>		COUNTY		STATE	
21. I <u>VIEWED</u> <u>ON</u> <u>8-7-59</u> attended the deceased from <u>11:45 A.M.</u> to <u>8-7-59</u> and last saw her/him alive on <u>8-7-59</u> . Death occurred at <u>11:45 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE <u>James L. Gentry, Coroner</u>			22b. ADDRESS <u>Cabool, Mo.</u>		22c. DATE SIGNED <u>8-7-59</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE <u>8-9-59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Cabool, Mo.</u>		
24. FUNERAL DIRECTOR <u>Elliott-Gentry, Cabool, Mo.</u>		ADDRESS	25. DATE RECD. BY LOCAL REG. <u>8-15-59</u>	26. REGISTRAR'S SIGNATURE <u>Gaynell Cunningham</u>		

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Richard A. Nord

Licensed Embalmer No. 5029

P. O. Address Mtn View

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.