

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-034861

FILED VS OCT 13 1959

STATE FILE NUMBER

Registration District No. 224 Primary Registration District No. 3072 Registrar's No. 156

INDEXED

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|--|--|---|--|---|---|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Saline | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Saline | | | | | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Marshall | | Length of stay in 1b Life | | c. CITY OR TOWN Marshall | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | | | |
| c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION Fitzgibbon Hosp. | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS (If outside, give location) 837 N Odell | | Resides on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print) First VIRGINIA Middle LEE Last BRAY | | | | 4. DATE OF DEATH Month Oct. Day 2, Year 1959 | | | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH 12-28-1901 | 9. AGE (last birthday) 57 | IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> | IF UNDER 24 HR Hours <input type="checkbox"/> Min. <input type="checkbox"/> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (City and state or country) Saline Co. Mo. | | 12. CITIZEN OF WHAT COUNTRY USA | | |
| 13a. FATHER'S NAME David Marks | | | 13b. MOTHER'S MAIDEN NAME Minnie Wyrick Marks | | | 14. NAME OF HUSBAND OR WIFE Carl Bray | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give war or dates of service) <input checked="" type="checkbox"/> | | | 16. SOCIAL SECURITY NO. 487-09-7121 | | 17. INFORMANT Address Marshall Mrs. Joseph Stephens 837 N Odell | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vas Accident. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 3- Day | | |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.) DUE TO (b) Cerebral Vas Thrombosis | | | | | | | 3- da | | |
| DUE TO (c) | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | | | | | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 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 <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. | | Month, Day, Year | | | | | | | |
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input 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 | |
| 21. I attended the deceased from July, 1959 to Oct 2, 1959 and last saw him alive on Oct 2, 1959 Death occurred at 11:10 A.m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | | | |
| 22a. SIGNATURE B. Knepper (Degree or title) ms. | | | | 22b. ADDRESS Marshall, Missouri | | | 22c. DATE SIGNED 10-5-59 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 10-5-1959 | 23c. NAME OF CEMETERY OR CREMATORY RidgePark Cemetery | | 23d. LOCATION (City, town, or county) Marshall, Missouri | | (State) | | |
| 24. FUNERAL DIRECTOR Sweeney-Reser Funeral Home Marshall | | | | ADDRESS 10-4-59 | | 25. DATE RECD. BY LOCAL REG. | | 26. REGISTRAR'S SIGNATURE Cecil Lead | |

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 me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jack W. Reese
Licensed Embalmer No. 4643

P. O. Address Marshall

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.