

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

61-025051  
3476 STATE FILE NUMBER

AMENDED

Registration District No. 149 Primary Registration District No. 1602 Registrar's No. \_\_\_\_\_

FILED JUL 28 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>Jackson</b>	b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kansas City</b>	a. STATE <b>Mo.</b>	b. COUNTY <b>Jackson</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>4737 Wyoming</b>		Length of stay in 1b <b>60 Yrs.</b>	c. CITY OR TOWN <b>Kansas City</b>
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS <b>4737 Wyoming</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First <b>MARY</b>	Middle <b>ALICE</b>	Last <b>BRAY</b>	4. DATE OF DEATH	Month <b>July</b>	Day <b>10,</b>	Year <b>1961</b>
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5. SEX <b>Fe.</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>1-21-1878</b>	9. AGE (last birthday) <b>83</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home Maker</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	11. BIRTHPLACE (City and state or country) <b>Carolton, Mo.</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Benjamin Corbin</b>	13b. MOTHER'S MAIDEN NAME <b>Claudia Carlton</b>	14. NAME OF HUSBAND OR WIFE <b>(Dec.) Edward M. Bray</b>
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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) <b>no</b>	16. SOCIAL SECURITY NO. <b>none</b>	17. INFORMANT <b>Helen Bernard, 4737 Wyoming</b>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:	INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Myocardial infarction acute</b>	<b>2 hrs</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	
DUE TO (b) <b>Generalized arteriosclerosis.</b>	
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
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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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **1948** to **June 1960** and last saw her **alive on June 30, 1961**  
Death occurred at **300 A** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <b>Donald M. Ireland M.D.</b>	22b. ADDRESS <b>Kansas City Mo.</b>	22c. DATE SIGNED <b>7-12-61</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7-13-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Maple Hill Cemetery</b>	23d. LOCATION (City, town, or county) <b>Kansas City, Kansas</b>	(State)
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24. FUNERAL DIRECTOR <b>Gates Funeral Home, K.C. Kans.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>7-12-61</b>	26. REGISTRAR'S SIGNATURE <b>Ruth Long</b>
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DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DR. DONALD M. IRELAND

RECORDS ARE AS FOLLOWS

Dr. McFarland  
Phygia W. M. Bldg.  
10-1-15-33.

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 Murray Wilson

Licensed Embalmer No. 4989

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