

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-040253

DEPARTMENT OF PUBLIC HEALTH AND WELFARE 042

1000 1176

STATE FILE NUMBER

AMENDED

Filed NOV 24 1961

Primary Registration District No. Registrar's No.

DATE AMENDED

INSTEAD OF

HEM NO. SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

MEDICAL CERTIFICATION

C. Smith, M.D.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY BUCHANAN | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Clinton | |
| b. CITY (if outside corporate limits, give TOWNSHIP only) OR TOWN ST. JOSEPH, | | Length of stay in lb | c. CITY OR TOWN Plattsburg, |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION STATE HOSPITAL NO. #2 | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) State Hospital |
| 3. NAME OF DECEASED (Type or print) First Middle Last GROVER CLEVELAND WRAY | | 4. DATE OF DEATH Month Day Year November 16, 1961 | |
| 5. SEX Male | 6. COLOR OR RACE white: | 7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH May 27, 1882 |
| 9. AGE (last birthday) 79 | | IF UNDER 1 YEAR Months Days | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | 11. BIRTHPLACE (City and state or country) Montgomery County, Mo. U.S.A. |
| 13a. FATHER'S NAME William J. Wray | | 13b. MOTHER'S MAIDEN NAME Virgina Tretry | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. 0 | |
| 17. INFORMANT Records- State Hospital- 263, St. Joseph, | | Address Box | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease | | | INTERVAL BETWEEN ONSET AND DEATH 8/21/61 to 11/16/61 |
| DUE TO (b) General Arteriosclerosis | | | over one year |
| 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 a.m. 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 Jan. 20, 1960 to Nov. 16, 1961 and last saw her alive on 11-16-61 Death occurred at 3:10 P.M. on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE <i>C. Smith, M.D.</i> | | 22b. ADDRESS State Hospital, St. Joseph, Mo. | 22c. DATE SIGNED 11-16-61 |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) | 23b. DATE 11/19/1961 | 23c. NAME OF CEMETERY OR CREMATORY Allen | 23d. LOCATION (City, town, or county) (State) Gower Mo. |
| 24. FUNERAL DIRECTOR Lyon Funeral Home, Plattsburg, Mo | | 25. DATE RECD. BY LOCAL REG. Nov. 19, 1961 | 26. REGISTRAR'S SIGNATURE <i>Mr. Clark Standell</i> |

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 Donald D. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg, N.Y.

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.