

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 8 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

12068
Do not use this space.

1. PLACE OF DEATH *Platte*
 (a) County *Platte* Registration District No. *698*
 (b) Township *Weston* Primary Registration District No. *1420* Registered No. _____
 (c) City *Weston* (d) Street No. _____ St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
 2. PRINT FULL NAME *Wm. D. Gray*
 (a) Residence, No. _____ St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Married*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Irene Kavanaugh*
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Apr 28 1881*
 7. AGE YEARS *58* MONTHS *10* DAYS *12* If LESS than 1 day, hrs. or min.
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. *Speculator*
 9. Industry or business in which work was done, as saw mill, bank, etc. *Tobacco*
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *March 10 1940*
 22. I HEREBY CERTIFY, That I attended deceased from _____, 19____ to _____, 19____
 I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at *12:30* a.m.
 The principal cause of death and related causes of importance were as follows:
Gushat wound through head caused & fired by another party instant death
 Date of onset _____
 Other contributory causes of importance: _____
 Name of operation *Examination* Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? *NO*
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? *Town*
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? _____
 If so, specify _____
 (Signed) *Leah N. Francis* *Carroll*
 (Address) *Palmerville Wm Platte*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 13. NAME *Sauford Gray*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 15. MAIDEN NAME *Elizabeth Williams*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*
 17. INFORMANT *W. A. Gray*
 (ADDRESS) *Weston mo*
 18. BURIAL, CREMATION, OR REMOVAL PLACE *Charlton* DATE *Mar 11 1940*
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) *Bill Mortuary*
Weston
 20. FILED *3/11 1940*
J. Brill
 Local Registrar.

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RECEIVED
District Health Officer No. 111
District File Number 440-433
Date Filed APR 3 1940

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

Registered Apprentice No., working under my personal supervision.

Signed

Licensed Embalmer No.

P. O. Address

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 this body is not embalmed, above space should be left blank.

Registration District No. 698

Primary Registration District No. 4420

Registrar's No. _____

1. PLACE OF DEATH

(a) County Platte
(b) City or town Weston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME

Omar D. Grant

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced _____

6. (b) Name of husband or wife _____

6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased _____

(Month) (Day) (Year)

8. AGE:

Years 58 Months 10 Days 12

If less than one day _____ hr. _____ min.

9. Birthplace _____

(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____

(City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____

(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 3-11-1940 (b) _____

(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____
(If outside city or town limits write "RURAL")
(d) Street No. _____
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 10
year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.
Immediate cause of death _____

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature Leland H. Francis (M.D. or other) _____
Address Partville _____ date signed _____

WRITE PLAINLY--USE UNFADING BLACK INK--MAKE A PERMANENT RECORD

SUPPLEMENTARY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 12068

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 698

Primary Registration District No. 4420

Registrar's No. _____

1. PLACE OF DEATH

(a) County Platte
(b) City or town Weston
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME D. D. Gray

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: Years 58 Months 10 Days 12 If less than one day _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

13. Birthplace _____ (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 10 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

Gunshot wound through head caused and fired by another party instant death

Due to _____ (Homicide) Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Homicide

(b) Date of occurrence March 10 - 1940

(c) Where did injury occur? Weston, Platte mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place) (c) Means of injury _____

23. Signature Leland H. Francis (M. D. or other) _____

Address Parkville mo Date signed _____

SUPPLEMENTAL

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD