

Registration District No. NOV 90 1940

Primary Registration District No. 1

Registrar's No. 258

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Kirksville
(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days
In this community 41 years
(Specify whether years, months or days)

3. (a) PRINT FULL NAME Goldie Josephine Gray

8. (b) If veteran, name war. _____ 8. (c) Social Security No. None

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

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

7. Birth date of deceased. June 29 1899
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
41 4 6 hr. _____ min.

9. Birthplace Adair Co., Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Practical Nursing

11. Industry or business _____

MOTHER FATHER { 12. Name Jacob C. Gray
13. Birthplace Fountain Co., Ind.
(City, town, or county) (State or foreign country)
14. Maiden name Sarah K. Lowrance
15. Birthplace Vermillion Co., Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Jacob C. Gray
(b) Address Stahl, Mo. R. R. #2

17. (a) Burial (b) Date thereof 11-7-40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Novinger Cemetery

18. (a) Signature of funeral director Dee Riley

(b) Address Kirksville, Mo.

19. (a) Nov. 8/40 (b) Spencer Freeman
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Adair
(c) City or town "Kirksville"
(If outside city or town limits, write "RURAL")
(d) Street No. 422 1/2 West. Filmore #2
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5
year 1940 hour 5:30 minute P. M.

21. I hereby certify that I attended the deceased from October twenty fourth, 1940, to November 5, 1940 that I last saw her alive on November fifth, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Generalized Toxemia

Due to Typhoid Fever

Due to Myocardial Failure (Myocarditis)

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

Major findings: Of operations No operation

Of autopsy No Autopsy

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? _____

3 While at work? _____ (Specify type of place) (e) Means of Injury 3

23. Signature A. R. Schultz (M.D. or other) D.O.
Address Community Nursing Home, Kirksville, Mo. Date signed 11/8/40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED

District Health Officer No. 10

District File Number 11-40-2135

Date Filed NOV 14 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.....

Laura A. Riley

Registered Apprentice No.....

working under my personal supervision.

Signed.....

Laura A. Riley

Licensed Embalmer No. 3907

P. O. Address Keokuk 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 this body is not embalmed, above space should be left blank.