DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34930

NOV 25 1940

Registration District No. 95 Primary Registration District No. 5141 4057 Registrar's No.

1. PLACE OF DEATH:

(a) County Caldwell

(b) City or town Cowgill Mo (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 years, months or days)

In this community 45 yrs

2. USUAL RESIDENCE OF DEACESED:

(a) State Mo (b) County Caldwell

(c) City or town Cowgill (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.

3. (a) PRINT FULL NAME JOHN GRAY

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Esther Gray

6. (c) ~~Age of husband~~ or wife if alive 73 years

7. Birth date of deceased Sept (Month) 16 (Day) 1859 (Year)

8. AGE: Years 81 Months 0 Days 24 If less than one day hr. min.

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

10. Usual occupation Blacksmith

11. Industry or business

FATHER

12. Name John Gray

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

MOTHER

14. Maiden name Ann Leslie

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

16. (a) Informant's own signature Mrs Esther Gray

(b) Address Cowgill Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct. 13 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Cowgill Cemetery

18. (a) Signature of funeral director Chas La Reed

(b) Address Cowgill Mo

19. (a) Oct 16 1940 (Date received by local registrar) (b) Mrs. M. D. Forbes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 10 year 1940 hour 10 minute P M.

21. I hereby certify that I attended the deceased from Aug 10, 1940, to Oct 10, 1940; that I last saw alive on Oct 10, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Terminal pneumonia

Due to Staphylococcus septicemia

Due to Infection of teeth.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature L. E. Johnson (M. D. or other) M.D.

Address Cowgill, Mo Date signed 10-11-40

(Licensed Embalmer's Statement on Reverse Side)

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

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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. 3 working under my personal supervision.

Signed C A Reed

Licensed Embalmer No. 2194

P. O. Address Conquill Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

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

. No. 2B
—2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34920

Registration District No. 95-

Primary Registration District No. 4057

Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH

(a) County: Caldwell

(b) City or town: Cowgill
(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 years, months or days)

In this community

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.

3. (a) PRINT FULL NAME: John 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: W

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 81 Months 0 Days 24 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from , 19, to , 19; that I last saw h alive on , 19; and that death occurred on the date and hour stated above.

Immediate cause of death: Terminal Pneumonia BRONCHIAL PNEUMONIA

Due to: Staphylococcus Septicemia

Due to: Infection of teeth

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations: 1070

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: DR. H. E. Johnson (M. D. or other)

Address: Cowgill, Mo. Date signed 12-11-40

SUPPLEMENTAL