

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 3999  
Registrar's No. 1

FILED JAN 17 1944  
Registration District No. 240

Primary Registration District No. 5986

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

1. PLACE OF DEATH:  
(a) County Pulaski  
(b) City or town Rural (Tavern T. S.)  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
In this community 1 month  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State \_\_\_\_\_ (b) County 85  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Sarah Frances Gray  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month JAN day 3  
year 1944 hour 8:30 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Dec 15 1943 to JAN 3 1944  
that I last saw her alive on JAN 3 1944  
and that death occurred on the date and hour stated above.

4. Sex Female / race White 5. Color or race \_\_\_\_\_  
6. (a) Single, widowed, married, divorced Widow  
6. (b) Name of husband or wife Robert Lee Gray 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased July 14, 1877  
(Month) (Day) (Year)

Immediate cause of death \_\_\_\_\_ Duration 6 MO.  
PULMONARY TUBERCULOSIS

8. AGE: Years 66 Months 5 Days 19  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions MYOCARDIAL FAILURE  
(Include pregnancy within 3 months of death)

9. Birthplace Pulaski Co. Mo.  
(City, town, or county) (State or foreign country)  
10. Usual occupation House Wife

Major findings: 13 fl  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

MOTHER FATHER { 11. Industry or business \_\_\_\_\_  
12. Name Wm. Robertson  
13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name Julia Robertson  
15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

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?

16. (a) Informant Lela Welch  
(b) Address 208 Durbin St. Garey, Ind.  
17. (a) burial (b) Date thereof 1/5/44  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Antioch Cem.  
18. (a) Signature of funeral director J. L. Hoops & Sons  
(b) Address Crocker, Mo.  
19. (a) Jan 13 1944 (b) Lela M. Welch  
(Date received local registrar) (Registrar's signature)

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury \_\_\_\_\_  
23. Signature John A. McWhorter (M.D. or other) DR  
Address Crocker, Mo. Date signed 1-5-44

**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 Paul B. Hooper

Licensed Embalmer No. 3261

P. O. Address Crook, Ma

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

**If this body is not embalmed, fact should be so stated above.**

Registration District No. 290 Primary Registration District No. 5986

1. PLACE OF DEATH:

(a) County Pulaski  
(b) City or town Rural Tavern Twp  
(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 Sarah J Gray

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

4. Sex F 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 \_\_\_\_\_ years

7. Birth date of deceased July 14 1942  
(Month) (Day) (Year)

8. AGE: Years 66 Months 5 Days \_\_\_\_\_ 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)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) Chas M Ouel  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski  
(c) City or town Rural Tavern Township  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ Day \_\_\_\_\_  
year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

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

Duration

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

