

FILED SEP 13 1944
Registration District No. 234

Primary Registration District No. 4349

Registrar's No. 16

1. PLACE OF DEATH:

(a) County MORGAN

(b) City or town STOVER
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MORGAN

(c) City or town STOVER
(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 _____

3. (a) PRINT FULL NAME SABINA WILCOX GRAY

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUG. day 10
year 1944 hour 6 minute 0 P. M.

21. I hereby certify that I attended the deceased from June 1944
to Aug 10 1944
that I last saw him alive on July 31 1944
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race WHITE

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

6. (b) Name of husband or wife GEORGE GRAY

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

7. Birth date of deceased: AUGUST 12 1853
(Month) (Day) (Year)

Immediate cause of death: uraemia Duration 10 days

Due to Chronic Nephritis

8. AGE: Years 90 Months 11 Days 28
If less than one day hr. min.

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

10. Usual occupation HOUSE WIFE

Due to Cardio-renal Syndrome 20296

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

MOTHER FATHER

11. Industry or business _____

12. Name RICHARD WILCOX

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

14. Maiden name ELIZABETH UNKNOWN

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

Major findings: 131A

Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

16. (a) Informant MRS. LOUIS ROCH

(b) Address COLE CAMP MO

17. (a) BURIAL (b) Date thereof AUG 12 1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation STOVER CEM.

18. (a) Signature of funeral director Papp Stevinson

(b) Address Stover Mo

19. (a) Aug 28 (b) Henry Trippe
(Date received local registrar) (Registrar's signature)

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? Yes (e) Means of injury 0

23. Signature Weg Sum (M. D. or other) _____
Address Versailles Mo Date signed 8/12/44

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

RECEIVED
District Health Officer No. 7;
District File Number 8-44-1062
Date Filed 9-12-44

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.....

J. L. Stearns

Licensed Embalmer No. 4073

P. O. Address *Stover, 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, fact should be so stated above.