DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 11 1946

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 41532

Registration District No. 157

Primary Registration District No. 3028

Registrar's No. 229

1. PLACE OF DEATH:

(a) County Jasper

(b) City or town Carthage
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: McCune-Brooks Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 hours (Specify whether
In this community 60 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jasper 4

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

(d) Street No. 302 W. Chestnut St 3
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No) 0

If yes, name country

3. (a) PRINT FULL NAME Kate Wray

3. (b) If veteran, name war —

3. (c) Social Security No. —

4. Sex female

5. Color or race white

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

6. (b) Name of husband or wife Rev. A.K. Wray

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

7. Birth date of deceased August (Month) 14 (Day) 1852 (Year)

8. AGE: Years 93 | Months 4 | Days 3 | If less than one day ___ hr. ___ min.

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

10. Usual occupation At Home

11. Industry or business — — —

FATHER
12. Name John Poole
13. Birthplace unknown (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Mary —
15. Birthplace unknown (City, town, or county) (State or foreign country) 9

16. (a) Informant Miss Emma R. Knell
(b) Address Carthage, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 20-1945 (Month) (Day) (Year)
(c) Place: burial or cremation Lamar, Mo - Lake Cem

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo

19. (a) 12-19-45 (Date received local registrar) (b) L.B. Clinton M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 17
year 1945 hour 8:30 minute p M.

21. I hereby certify that I attended the deceased from Dec. 15, 1945, to Dec. 17, 1945; that I last saw her alive on Dec. 17, 1945 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Senility	
Due to Terminal Pneumonia	
Due to Influenza	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 33 hr

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 R. N. Nebstad (M. D. or other)
Address Carthage Mo Date signed Dec. 18 45

1458 (Licensed Embalmer's Statement on Reverse Side)

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

HS-NL-992

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.....Emm R Knapp

Licensed Embalmer No.....391

P. O. Address.....Carthage

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.