

**FILED JUN 14 1946**

Registration District No. \_\_\_\_\_

Primary Registration District No. **2033 4264**

Registrar's No. **881081**

1. PLACE OF DEATH:

(a) County Laclede  
(b) City or town Conway  
(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 Laclede  
(c) City or town Conway  
(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 George Watson M. Kay

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. none

4. Sex m 5. Color or race W 6. (a) Single, widowed, married, divorced widowed  
6. (b) Name of husband or wife Sophronia J. M. Kay 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Aug 17 1861  
(Month) (Day) (Year)

8. AGE: Years 85 Months 6 Days 12 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Retired farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Moses A. M. Kay  
13. Birthplace Ind. (City, town, or county) (State or foreign country)  
14. Maiden name Karey Finn  
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Bliss M. Kay  
(b) Address Conway Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-11-46  
(Month) (Day) (Year)  
(c) Place: burial or cremation Conway Baptist Cemetery

18. (a) Signature of funeral director W.E. Heilman  
(b) Address Lebanon Mo.  
19. (a) June 1, 1946 (b) Ors Frankberger  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 9  
year 1946 hour 3 minute 30 A.M.

21. I hereby certify that I attended the deceased from 2 Jan 7 1946 to 9 Mar 9 1946  
that I last saw him alive on 9 Mar 9 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of Stomach

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

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

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? \_\_\_\_\_  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. W. Hindray (M. D. or other) MO  
Address Conway Date signed 3-18-46

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

Received ..... 6/12/46 .....

Laclede County Health Unit

File No. .... 3-46-60 .....

Date Filed ..... 6/12/46 .....

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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.....  
working under my personal supervision.

Signed *Dorsey M. Howe* .....

Licensed Embalmer No. *4222* .....

P. O. Address *Lebanon, 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.