

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

37843

FILED DEC 6 1946

Registration District No. 251

Primary Registration District No. 4379

Registrar's No. 175

1. PLACE OF DEATH:

(a) County Nodaway
 (b) City or town Pickering, Missouri
 (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 12 Years. (Specify whether years, months or days)

3. (a) PRINT FULL NAME Bayard Taylor Wray

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 Widowed
 6. (b) Name of husband or wife: _____
 6. (c) Age of husband or wife if alive 10, 1862 years

7. Birth date of deceased: January 10, 1862
 (Month) (Day) (Year)

8. AGE: Years 84 Months 10 Days 8 If less than one day hr. _____ min. _____

9. Birthplace: Nodaway County Missouri
 (City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business None

12. Name William W. Wray

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

14. Maiden name Sarah Shelman

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

16. (a) Informant Mr. Arthur Wray

(b) Address Pickering, Missouri

17. (a) Burial (b) Date thereof 11/20/46
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation White Oak Cemetery

18. (a) Signature of funeral director Price Funeral Home

(b) Address Maryville, Missouri

19. (a) Nov 21-46 (b) Bess Holt
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Nodaway 74
 (c) City or town Pickering
 (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 Nov. day 19th
 year 1946 hour 1:00 minute _____ P. _____ M. _____

21. I hereby certify that I attended the deceased from Nov 14
 1946, to Nov 18 1946
 that I last saw him alive on Nov. 14 1946
 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 8 days
 Due to Arterial Sclerosis

Due to _____

Other conditions (Include pregnancy within 3 months of death)
Cerebral Debility

Major findings: Of operations none

Of autopsy none 83A

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 Engineer R. Brown (M. D. or other) _____

Address Pickering Mo Date signed 11-29

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

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(Licensed Embalmer's Statement on Reverse Side)

DISTRICT HEALTH OFFICE
Cameron, Mo.

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..... *W. M. Lee*

Licensed Embalmer No..... *2639*

P. O. Address.....

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.