

S. No. 2  
M-8-43  
v. 5-17-39  
PI X37823

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 33398

FILED SEP 30 1947 26

Registration District No. \_\_\_\_\_ Primary Registration District No. 6104

Registrar's No. 55-

1. PLACE OF DEATH:

(a) County Scotland

(b) City or town RURAL, MILLER  
(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 years, months or days)

In this community 40 YEARS

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County SCOTLAND

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

(d) Street No. MILLER TOWNSHIP  
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ROSA CATHERINE RAY

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 19  
year 1947 hour 1 minute A.M.

4. Sex FEMALE 5. Color or race W

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

6. (b) Name of husband or wife H.M. RAY 6. (c) Age of husband or wife if alive 70 years

7. Birth date of deceased MAY 28 1885  
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from SEP 2 1947 to SEP 5 1947  
that I last saw him/her alive on SEP 5 1947  
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion  
Angina Pectoris

8. AGE:	Years	Months	Days	If less than one day
	<u>62</u>	<u>3</u>	<u>23</u>	hr. _____ min. _____

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

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

Other conditions Call Stomach  
(Include pregnancy within 3 months of death)

9. Birthplace ADAIR COUNTY Mo  
(City, town, or county) (State or foreign country)

10. Usual occupation HOUSE KEEPER

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

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

Of autopsy No

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

12. Name Edwin Berry

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

14. Maiden name Mary Laurette

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) No.

(b) Date of occurrence None

(c) Where did injury occur? None  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
None

While at work? No (Specify type of place) (e) Means of injury \_\_\_\_\_

MOTHER FATHER

16. (a) Informant Byford Jack

(b) Address Memphis Mo

17. (a) Burial (b) Date thereof 9-21-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Little Zion

18. (a) Signature of funeral director H. E. Gerwig

(b) Address Memphis Mo

19. (a) Sept 26 1947 (b) Wm. E. E. Parvish  
(Date received local registrar) (Registrar's signature)

23. Signature H. E. Gerwig (M. D. or other) \_\_\_\_\_  
Address Dawning Mt Date signed SEP 25

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

79  
0  
0

NOV 30 1949

FEB 10 1950

RECEIVED  
District Health Officer No. 10  
District File Number 9-47-1323  
Date Filed SEP 29 1947

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 Neal Payne  
Licensed Embalmer No. 2550  
P. O. Address Memphis

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.