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STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

FILED NOV 29 1948
Registration District No. 2281

Primary Registration District No. 3248

Registrar's No. 276

1. PLACE OF DEATH:

(a) County NODAWAY
(b) City or town MARYVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
MARTIN LANDERTHER HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 34 HRS (Specify whether
In this community _____
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Worth
(c) City or town Sheridan
(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 Louise Henretta 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 married
6. (b) Name of husband or wife William N. Wray 6. (c) Age of husband or wife if alive 81 years
7. Birth date of deceased March 17 1875
(Month) (Day) (Year)

8. AGE: Years 73 Months 7 Days 27 If less than one day
hr. _____ min. _____

9. Birthplace Lost Nation Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation housewife

11. Industry or business _____

MOTHER FATHER

12. Name Fred Othman
13. Birthplace Hanover Germany
(City, town, or county) (State or foreign country)
14. Maiden name Mary Johanson
15. Birthplace Denmark
(City, town, or county) (State or foreign country)

16. (a) Informant William N. Wray
(b) Address Sheridan, Mo.

17. (a) Burial (b) Date thereof 11-18-1948
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sheridan, Mo.

18. (a) Signature of funeral director Arch C. Dunfee

(b) Address Grant City, Mo.

19. (a) 11-20-48 (b) Bess Holt
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 14
year 1948 hour 9: minute 30 a.m.

21. I hereby certify that I attended the deceased from Nov. 12, 1948 to Nov. 14, 1948
that I last saw her alive on Nov. 14, 1948
and that death occurred on the date and hour stated above.

Immediate cause of death
INTERTRACHANTERIC FRACTURE LEFT FEMUR

Due to _____

Due to _____

Other conditions CHRONIC MYOCARDITIS
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) accident 113
(b) Date of occurrence 11-12-48
(c) Where did injury occur? SHERIDAN, WORTH, MO.
(City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
METHODIST CHURCH.

While at work? _____ (Specify type of place)
(c) Means of injury fell down steps

23. Signature W. L. Landreth (M. D. or other) DO.
Address Maryville, Mo. Date signed 11-14-48

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

HEALTH OFFICE
MERCER, 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... *Arch C. Dunfee*

Licensed Embalmer No. *3252*

P. O. Address. *Front city 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.