

Registration District No. _____

Primary Registration District No. _____

Registrar's No. _____

1. PLACE OF DEATH:

- (a) County Shannon
 (b) City or town Ironwood, Mo
 (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. (Specify whether

In this community _____ years, months or days 33. (a) PRINT FULL NAME ADA ADALINE GRAY3. (b) If veteran, name war ✓ 3. (c) Social Security No. ✓4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED6. (b) Name of husband or wife BEEH GRAY 6. (c) Age of husband or wife if alive _____ years7. Birth date of deceased OCT 20 1872
(Month) (Day) (Year)8. AGE: Years 68 Months 1 Days 1 If less than one day _____ hr. _____ min.9. Birthplace SEDALIA MO
(City, town, or county) (State or foreign country)10. Usual occupation ANIMAL TRAINER

11. Industry or business _____

12. Name S. HULEY13. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)14. Maiden name UNKNOWN15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)16. (a) Informant's own signature BEEH GRAY(b) Address Ironwood, Mo.17. (a) Burial (b) Date thereof 11-22-40
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation K.P. CEMETERY18. (a) Signature of funeral director Frankie Hayden(b) Address Ironwood19. (a) 11-22-40 (b) Frankie Hayden, MD
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____
(If outside city or town limits, write "RURAL")(d) Street No. _____
(If rural, give location)

(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 11 day 23
year 1940 hour 12 minute AM

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;

that I last saw him _____ alive on _____, 19____,
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Due to Unknown CauseDue to Found dead.Other conditions _____
(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) _____

(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? _____

7401
While at work _____ (Specify type of place)

(a) Means of injury _____

23. Signature Frankie Hayden Co. Physician (M. D. or other) _____Address Ironwood, Mo Date signed 11-22-40

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 8,

District File Number... 12401214

Date Filed _____

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 J. Allen Davis
Licensed Embalmer No. 4053
P. O. Address W. S. Jones

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, above space should be left blank.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4404-3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 822

Primary Registration District No. 4498

Registrar's No.

1. PLACE OF DEATH:

(a) County *Shannon*
(b) City or town *Chambers*
(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. (Specify whether

In this community
years, months or days)

3. (a) PRINT FULL NAME

Ada Adaline Gray

3. (b) If veteran, name war.

3. (c) Social Security No.

4. Sex

F

5. Color or race *W*

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

6. (b) Name of husband or wife

6. (c) Age of husband, or wife, if alive. year

7. Birth date of deceased.

(Month)

(Day)

(Year)

8. AGE:

Years

Months

Days

If less than one day

68

1

1

hr. min.

9. Birthplace

(City, town, or county)

(State or foreign country)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

(City, town, or county)

(State or foreign country)

14. Maiden name

15. Birthplace

(City, town, or county)

(State or foreign country)

16. (a) Informant

(b) Address

17. (a)

(Burial, cremation, or removal)

(b) Date thereof

(Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a)

11-23-40
(Date received local registrar)

(b)

Frank Hyde MD
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State *Mo* (b) County *Shannon*

(c) City or town *Chambers Mo*
(If outside city or town limits write "RURAL")

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

(e) If foreign born, how long in U. S. A. ? years.

DEATH CERTIFICATION

20. DATE OF DEATH Month *11* day *23*
year *1940* hour minute M.

21. I hereby certify that I attended the deceased from
19..... to..... 19.....

that I last saw h..... alive on..... 19.....

and that death occurred on the date and hour stated above.

Immediate cause of death

Duration

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

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 *Frank Hyde* (M. D. or other)

Address *Emmerson* Date signed

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

SUPPLEMENTAL COPY

