

Registration District No. 297

Primary Registration District No. 6020

Registrar's No. 1

1. PLACE OF DEATH:

(a) County Ray
(b) City or town Richmond, Rural (outside)
(c) Name of hospital or institution: None
(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 Ray
(c) City or town Richmond Rural
(d) Street No. Eight Miles North East.
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME William Mac. Gorham

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Mary Elizabeth Gorham 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased Aug. 24 1869
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
75 4 27 hr. min.

9. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business _____

MOTHER FATHER { 12. Name T. J. Gorham
13. Birthplace Ray Co. Mo.
14. Maiden name Sarah Scholler
15. Birthplace Ray Co. Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant James J. Gorham
(b) Address Richmond. Mo.

17. (a) Burial (b) Date thereof Jan. 21, 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Sandels Cemetery

18. (a) Signature of funeral director [Signature]
(b) Address Richmond. Mo.
19. (a) Jan 21 1945 (b) Miss Sarah Scholler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 20
year 1945 hour 5 minute 45 A.M.

21. I hereby certify that I attended the deceased from Jan 14, 1945 to Jan 20, 1945
that I last saw him alive on Jan 20, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Apoplexy Duration 1 wk.
Due to Arterial Sclerosis + Hypertension
Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations [Signature] 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) Means of injury _____
23. Signature Dr. E. J. Kerane (M.D. or other) [Signature]
Address Richmond, Mo. Date signed Jan 21 1945

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

900

RECEIVED

District Health Officer No. 8,

District File Number

Date Filed

2-13-45

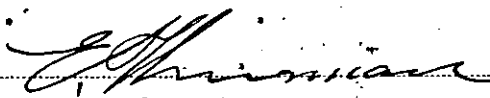
STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me for 15

Registered Apprentice No.

working under my personal supervision.

Signed



Licensed Embalmer No. 2073

P. O. Address Richmond, 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: