

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

28287  
Do not use this space.

RECD SEP 6 1939

**1. PLACE OF DEATH**

(a) County Jackson Registration District No. 399  
 (b) Township Haw Primary Registration District No. 1002 Registered No. 3703  
 (c) City Kansas City (d) Street No. St Joseph Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred 3 yrs - mos 1 ds (f) How long in U.S., if of foreign birth? yrs. mos. ds.

**2. PRINT FULL NAME**

(a) Residence, No. 1110 East Lombard St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8-18-39

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
1

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Kansas City Missouri

13. NAME Chelcie E Ray

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Indiana

15. MAIDEN NAME Amy Sutton

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri

17. INFORMANT (ADDRESS) Chelcie E Ray 1110 E Lombard, City

18. BURIAL, CREMATION, OR REMOVAL PLACE Not Movable DATE 8-19-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Freeman Mortuary 104 W 42 St KC Mo

20. FILED Aug 20, 1939 M. M. Crowe, Local Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug 19, 1939

22. I HEREBY CERTIFY, That I attended deceased from Aug 17, 1939 to Aug 18, 1939

I last saw him alive on Aug 18, 1939 Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Uremia Date of onset May 15

Other contributory causes of importance: (Signature) M. M. Crowe

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_  
 Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased?  
 If so, specify \_\_\_\_\_  
 (Signed) Dr. John C. Skinner, M. D.  
 (Address) 1000 Bright St. St. Louis

K. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE CAREFULLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**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.....

Licensed Embalmer No.....

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, above space should be left blank.**