

N. 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.

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29529
Do not use this space.

REC'D SEP 7 1939

1. PLACE OF DEATH Lafayette

(a) County Lafayette Registration District No. 460

(b) Township Dover Primary Registration District No. 5623

(c) City Confederate Home (d) Street No. _____ St.

(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Andrew Jackson Ray

(a) Residence, No. _____ St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept 23rd 1844

YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>94</u>	<u>9</u>	<u>13</u>	

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) New Franklin (STATE OR COUNTRY) Mo.

13. NAME Andrew

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

15. MAIDEN NAME _____

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

17. INFORMANT (ADDRESS) River Kirby
Confederate Home

18. BURIAL, CREMATION, OR REMOVAL PLACE Confederate Home 7/5/39

19. FUNERAL DIRECTOR (NAME) A. H. Hader
(ADDRESS) Higginsville, Mo.

20. FILED Sept 1 1939 Jay Webb
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-3, 1939

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1936, to July 3, 1939

I last saw him alive on July 31, 1939. Death is said to have occurred on the date stated above, at 10 P.M.

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

Apoplexy -
Paralysis
Arteriosclerosis

Other contributory causes of importance: Stroke

Date of onset 7-3-39

Name of operation none Date of _____

What test confirmed diagnosis? no 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? no
If so, specify _____
(Signed) Carroll W. Webb M. D.
Higginsville, Mo. 413 (Address)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 9/5/39

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..... *M. W. [Signature]*

Licensed Embalmer No.....

P. O. Address *Hyquerville [Signature]*

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.