

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.

1939 OCT 12 1939

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

32520

Do not use this space.

## 1. PLACE OF DEATH

- (a) County Howard Registration District No. 380  
(b) Township 1 Primary Registration District No. 4224  
(c) City New Franklin (d) Street No. \_\_\_\_\_  
(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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. 22

## 2. PRINT FULL NAME

- (a) Residence, No. John Felix Ray St.   
New Franklin Mo.  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

## PERSONAL AND STATISTICAL PARTICULARS

|  |   |   |
|--|---|---|
| 3. SEX<br><u>male</u>  | 4. COLOR OR RACE<br><u>White</u>  | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)<br><u>married</u> |
| 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF<br><u>Lucinda Madison Ray</u>   |   |   |
| 6. DATE OF BIRTH (MONTH, DAY, AND YEAR)<br><u>Feb. 8 - 1866</u>                              |   |   |
| 7. AGE   | YEARS<br><u>73</u>  | MONTHS<br><u>7</u>  |
|  | DAYS<br><u>17</u>   | IF LESS than 1 day, _____ hrs. or _____ min.                                |
| OCCUPATION   | 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.<br><u>Retired Farmer</u> |   |
|  | 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)<br><u>1934</u>                            |   |
|  | 11. Total time (years) spent in this occupation<br><u>Life</u>  |   |
| 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Howard Co. Mo.</u>                    |   |   |
| FATHER   | 13. NAME<br><u>James Ray</u>  |   |
|  | 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Kentucky</u>   |   |
| MOTHER   | 15. MAIDEN NAME<br><u>Radosia Lankle Ray</u>  |   |
|  | 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)<br><u>Tenn.</u>  |   |
| 17. INFORMANT (ADDRESS)<br><u>Mrs. Lucinda Ray</u><br><u>New Franklin Mo.</u>                |   |   |
| 18. BURIAL, CREMATION, OR REMOVAL<br>PLACE <u>Mt Pleasant</u> DATE <u>9-27-39</u>            |   |   |
| 19. FUNERAL DIRECTOR (NAME) (ADDRESS)<br><u>J. S. Blankenship</u><br><u>New Franklin Mo.</u> |   |   |
| 20. FILED <u>9-26-39</u> <u>Clara T. Landrum</u><br>Local Registrar.                         |   |   |

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 26/39 1939

22. I HEREBY CERTIFY, That I attended deceased from Sept 10 1939, to Sept 25 1939  
I last saw him alive on Sept 25 1939. Death is said to have occurred on the date stated above, at 6:28 m.  
The principal cause of death and related causes of importance were as follows:  
Broncho-pneumonia Date of onset Sept 10 - 1939

Other contributory causes of importance: 107 W  
Senility

Name of operation none Date of \_\_\_\_\_  
What test confirmed diagnosis? none 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) Ed Chamberlain, M. D.  
(Address) New Franklin Mo.

RECEIVED  
District Health Officer No. 8  
License File Number  
Date Filed 10/9/39

**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 H. L. Pull

Licensed Embalmer No. 3515

P. O. Address New Franklin

**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.**