

Registration District No. 460

Primary Registration District No. 5623

Registrar's No. 42

1. PLACE OF DEATH:

(a) County Lafayette Mo.

(b) City or town Hodge  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Rural  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 20  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME John Ray

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex M race W

5. Color or \_\_\_\_\_

6. (a) Single, widowed, ~~married~~, divorced \_\_\_\_\_

6. (b) Name of husband or wife Nancy Jane Ray alive \_\_\_\_\_ years

6. (c) Age of husband or wife if \_\_\_\_\_

7. Birth date of deceased 2 12 1853  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>87</u>	<u>6</u>	<u>23</u>	hr. _____ min. _____

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

10. Usual occupation Farmer

11. Industry or business B. Ray

12. Name Kentucky

13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

14. Maiden name Rachael Brewster

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

16. (a) Informant John T. Ray

(b) Address Hodge, Mo

17. (a) Burial (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Mt Hope Cem

18. (a) Signature of funeral director Wallis Marshall

(b) Address Canalton Mo

19. (a) 9-14-40 (b) T. J. Webb  
(Date received local registrar) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Hodge, 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 5  
year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from June 30, 1940, to Sept 5, 1940  
that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic interstitial Nephritis

Due to \_\_\_\_\_

Due to 46

Other conditions Cancer of stomach  
(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? 413

(Specify type of place) \_\_\_\_\_  
While at work \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature Dr. James P. D. \_\_\_\_\_  
Address Waverly, Mo \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 8,  
District File Number  
10-4-40  
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. W. [Signature]*

Licensed Embalmer No. 1783

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, fact should be so stated above.**