

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.

NOV 20 1940

Registration District No. 007

Primary Registration District No. 3033

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Linnema

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

(d) Length of stay: In hospital or institution 6 days
(Specify whether years, months or days)

In this community 25 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pike

(c) City or town Bohring Green 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.

3. (a) PRINT FULL NAME Anna Bell Ray

3. (b) If veteran, _____ name war _____

3. (c) Social Security No. 20

4. Sex Female

5. Color or race W

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife Sam S. Ray - Deed-

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Dec. - 30 - 1871
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>68</u>	<u>9</u>	<u>17</u>	hr. _____ min. _____

9. Birthplace Hardin Co., Ohio
(City, town, or county) (State or foreign country)

10. Usual occupation at Home

11. Industry or business _____

MOTHER FATHER

12. Name Mansie N. Dally

13. Birthplace Platt Co Ill
(City, town, or county) (State or foreign country)

14. Maiden name Sarah J. Latimer

15. Birthplace Hardin Co Ohio
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Hospital Record

(b) Address _____

17. (a) Burial (b) Date thereof Oct. 19 - 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Bohring Green

18. (a) Signature of funeral director W. B. S. Brown

(b) Address Bohring Green

19. (a) 10/18/40 (b) Octaler
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 17th, year 1940 hour 3 minute 30 A M.

21. I hereby certify that I attended the deceased from Oct. 14th, 1940 to Oct. 17th, 1940; that I last saw her alive on Oct. 16th, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Due to _____

Due to _____

Other conditions Arterial hypertension
(Include pregnancy within 3 months of death)

Major findings: Of operations none

Of autopsy none

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)

(e) Means of injury _____

23. Signature B. B. Bragg M.D. (M. D. or other) _____

Address Bohring Green Mo. Date signed 10/18/40

RECEIVED

District Health Officer No. 10

District File Number 11-40-2071

Date Filed

NOV 8 1940

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. B. Moore

Licensed Embalmer No.

3466

P. O. Address

Bowling Green

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.