DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

DEC 5 - 1940

11-10-39
5-17-39
X21492

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

38582

State File No.

Registration District No. 232 Primary Registration District No. 5832 Registrar's No. 64

1. PLACE OF DEATH:

(a) County DAVIESS,

(b) City or town GILLMAN CITY, RURAL, LINCOLN TWNS

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

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community Life V

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County DAVIESS

(c) City or town GILLMAN CITY MO RURAL

(If outside city or town limit, write "RURAL")

(d) Street No. 0 (If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME LAURA ELMA RAY

3. (b) If veteran, name war —

3. (c) Social Security No.

4. Sex FE

5. Color or race W

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

6. (b) Name of husband or wife TONY R. RAY

6. (c) Age of husband or wife if alive 66 years

7. Birth date of deceased SEPT (Month) 20 (Day) 1875 (Year)

8. AGE: Years 65 Months 1 Days 7 If less than one day hr. min.

9. Birthplace MO (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE 0

11. Industry or business —

FATHER 12. Name TONY CARTY 1

13. Birthplace IOWA (City, town, or country) (State or foreign country)

MOTHER 14. Maiden name MARTHA WELBORN 1

15. Birthplace IOWA (City, town, or county) (State or foreign country)

16. (a) Informant T. R. RAY

(b) Address GILLMAN CITY, MO.

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 10-29-40 (Month) (Day) (Year)

(c) Place: burial or ~~cremation~~ PILOT GROVE CEM.

18. (a) Signature of funeral director [illegible]

(b) Address [illegible]

19. (a) 10-29-40 (Date received local registrar) (b) Nell Wiles (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 27 year 1940 hour 4:50 minute P.M.

21. I hereby certify that I attended the deceased from Sept 4, 1940, to Oct 27, 1940, that I last saw her alive on Oct 23, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pneumonia	8 days
Due to Bronchial Tumor	1 year
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature W. L. Warren (M. D. or other)

Address Gilman City Mo Date signed 10/29/40

(Licensed Embalmer's Statement on Reverse Side)

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

194

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 wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

No. 2B
-2-21-40
I X22659

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 38582

Registration District No. 252

Primary Registration District No. 5352

Registrar's No.

1. PLACE OF DEATH:

(a) County: Daviess

(b) City or town: Lincoln T.P.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

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

In this community

3. (a) PRINT FULL NAME: Laura Elma Ray

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years 65 Months 1 Days 7 If less than one day ... hr. ... min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town (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 10 day 27 year 1940 hour minute M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h. alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Pneumonia (Duration)
Bronchial Pneumonia
Bronchial Pneumon

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

23. Signature: W. L. Warren (M. D. or other) MD
Address: Gilman City Mo Date signed 2-7-41

SUPPLEMENTARY