

5-17-39
1 X2149

FILED **JAN 25 1941** **400**

Registration District No. _____ Primary Registration District No. **555313** Registrar's No. **4**

8

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

1. PLACE OF DEATH:

(a) County **Jackson**
 (b) City or town **Independence R 24**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **WMAI**
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **11**
(Specify whether years, months or days)

In this community **3 yrs**
(Specify whether years, months or days)

8. (a) PRINT FULL NAME **Ray James White**

3. (b) If veteran, name war **no** **8. (c) Social Security** No. **no**

4. Sex **m** **5. Color or** **W**
race

6. (a) Single, widowed, married, **6. (c) Age of husband or wife if**
 divorced **never** **alive** **years**

6. (b) Name of husband or wife **Ida White**

7. Birth date of deceased **Jan 1-1879**
(Month) (Day) (Year)

8. AGE:			If less than one day
Years	Months	Days	
61	11	30	hr. min.

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

10. Usual occupation **Farmer**

11. Industry or business **Farm**

MOTHER { **12. Name** **James White**
18. Birthplace **England**
14. Maiden name **Clara White**
15. Birthplace **unknown Ohio**
(City, town, or county) (State or foreign country)

FATHER { **16. (a) Informant** **Ray White**
(b) Address **Independence mo R 24**
17. (a) removal **(b) Date thereof** **1-2-41**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **The Fremont ch**

18. (a) Signature of funeral director **H. B. Langford**
(b) Address **Lee's Summit mo**

19. (a) 1-2-41 (b) Sara S. Barner
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Jackson**
 (c) City or town **Independence R 24**
(If outside city or town limits, write "RURAL")
 (d) Street No. **102m North on Lee's Summit Road**
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **31**
 year **1940** hour **8** minute **25 P.** M.

21. I hereby certify that I attended the deceased from **9-21**, 19**39**, to **12-31**, 19**40**
 that I last saw him alive on **12-31**, 19**40**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Hypostatic pneumonia** **3da**
 Due to **Cerebral Hemorrhage** **1927**
Complete Paralysis of
both Arms & Legs

Other conditions **(Include pregnancy within 3 months of death)**

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 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?
9 7 7
(Specify type of place)
 While at work? _____ (e) Means of injury _____

23. Signature **[Signature]** (M. D. or other) **100**
 Address **Lee's Summit** Date signed **1/2/41**

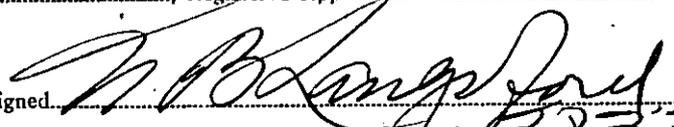
82a

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. 3833

P. O. Address West Summit, Mo.

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 42802

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 400

Primary Registration District No. 5563

Registrar's No.

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

MOORE

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Plains, 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 _____)

In this community _____ (Specify whether _____)

years, months or days

3. (a) PRINT FULL NAME Ray James White

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex _____

5. Color or race _____

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

6. (b) Name of husband or wife _____

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

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

8. AGE:

Years	Months	Days	If less than one day
61	11	30	hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) _____ (Day) _____ (Year)

(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (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.

20. DATE OF DEATH: Month Dec day 31 year 1940 hour _____ minute _____ M.

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

Immediate cause of death Hypostatic
Pneumonia
(Bronchopneumonia)
Due to cerebral hemorrhage
Complete paralysis of
both arms & legs

Other conditions _____ (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? _____

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

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

Address _____ Date signed 7/4/41

SUPPLEMENTAL ONLY

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

S-42802