

L. No. 4-13-4
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 12 1942

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

27133

State File No. _____
Registrar's No. 569

Registration District No. 128
Primary Registration District No. 5466

1. PLACE OF DEATH:
(a) County: GREENE
(b) City or town: Springfield Rural & Campbell Twp
(c) Name of hospital or institution: MEDICAL CENTER FOR FEDERAL PRISONERS 2
(d) Length of stay: In hospital or institution 2 Months, 24 Days
In this community 2 Months, 24 Days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Florida
(b) County: Orange
(c) City or town: Orlando
(d) Street No.: 210 North Parramore
(e) If foreign born, how long in U. S. A.: 0 years.

3. (a) PRINT FULL NAME: BROWN, Ray

3. (b) If veteran, name war: none
3. (c) Social Security No.: none

4. Sex: Male 2
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: none
6. (c) Age of husband or wife if alive: XX years

7. Birth date of deceased: April 13 1923

8. AGE: Years 19 Months 3 Days 18
If less than one day hr. min.

9. Birthplace: Orlando, Florida

10. Usual occupation: laborer

11. Industry or business: _____

MOTHER FATHER
12. Name: unknown
13. Birthplace: Unknown Unknown
14. Maiden name: Mamie Davis
15. Birthplace: Unknown Unknown
16. (a) Informant: Deceased

(b) Address: _____

17. (a) Burial (b) Date thereof: 8/14/42

(c) Place: burial or cremation: East Lawn

18. (a) Signature of funeral director: Fred C. Thimmes

(b) Address: Springfield, Mo.

19. (a) 8-3-42 (b) R.W. McComas

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 1
year 1942 hour 11 minute 30 P.M.

21. I hereby certify that I attended the deceased from May 8 1942, to August 1, 1942,
that I last saw him alive on August 1, 1942,
and that death occurred on the date and hour stated above.

Immediate cause of death: Tuberculosis Pulmonary (chronic)

Due to: _____
Due to: _____

Other conditions: _____

Major findings: Of operations: None

Of autopsy: Extensive tubercular involvement of both lungs.

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? _____

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____

23. Signature: R.A. McComas
Address: R.W. McComas, Clinical Director

Duration
Prior to Adm.

PHYSICIAN

Underline the cause to which death should be charged statistically.

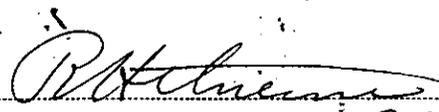
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

3681

P. O. Address.....

Springfield, 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, fact should be so stated above.



MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 217133-

Registration District No. 128

Primary Registration District No. 5466

Registrar's No. 569

1. PLACE OF DEATH

(a) County Shrew
(b) City or town Rural
(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 _____ years, months or days)

3. (a) PRINT FULL NAME Brown - Ray
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced S
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased April 13 1942
(Month) (Day) (Year)

8. AGE: Years 19 Months 3 Days 10 If less than one day _____ min.

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

10. Usual occupation _____
11. Industry or business _____

MOTHER FATHER { 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 Keep Records
(b) Address _____

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

18. (a) Signature of funeral director _____

(b) Address _____
19. (a) Jan 21-43 (b) D W J Handley
(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) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April Day 13 Year 1942 Hour _____ Minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____; that I have a written certificate of death on file on _____, 19____; and that death occurred on the date and hour stated above.
Immediate cause of death _____

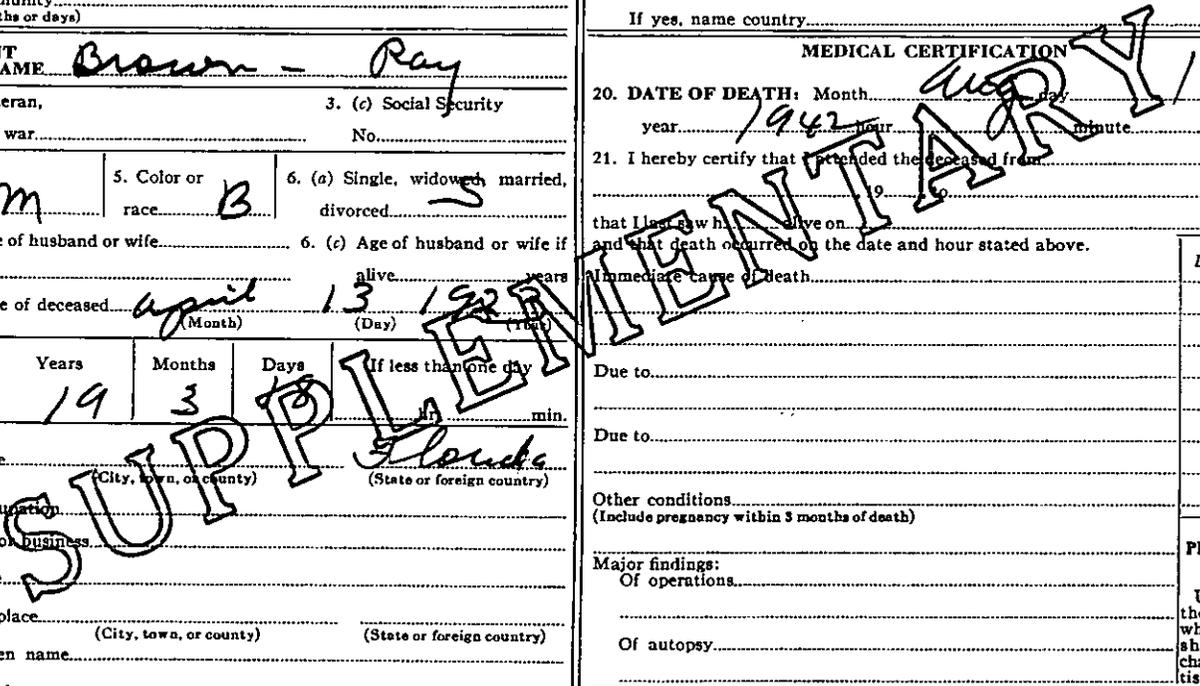
Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

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

23. Signature _____ (M. D. or other)
Address _____ Date signed _____

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



S-27133