

FILED AUG 11 1943

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

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural - Morrow Twp  
(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 Life \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Adair

(c) City or town Rural  
(If outside city or town limits, write "RURAL")

(d) Street No. Near Green Castle  
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)

If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME ASA WILSON RAY

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

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 16  
year 1943 hour 5 minute P.M.

21. I hereby certify that I attended the deceased from July 11  
1943 to July 16 1943  
that I last saw him alive on July 15 1943  
and that death occurred on the date and hour stated above.

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced Widowed

6. (b) Name of husband or wife Mary Ellen 6. (c) Age of husband or wife if alive 43 years

7. Birth date of deceased August 18 1856  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>86</u>	<u>10</u>	<u>28</u>	_____ hr. _____ min.

Immediate cause of death Chronic Valvular Heart Disease and Chronic Nephritis

Duration 10 yrs  
10 yrs

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: None

Of operations \_\_\_\_\_

Of autopsy None

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

10. Usual occupation Farmer

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Ray

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

14. Maiden name Hannah Phillips

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

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 \_\_\_\_\_

16. (a) Informant Willie Ray

(b) Address Green Castle Mo.

17. (a) Burial (b) Date thereof 7-19-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Green Castle Cem.

18. (a) Signature of funeral director Wm. E. Paulson

(b) Address Green City Mo.

19. (a) 7/19/43 (b) Mrs. J. W. Wapner  
(Date received local registrar) (Registrar's signature)

22. Signature H. P. Garrison M.D.  
Address Springer Mo. Date signed 7-16-43

RECEIVED

District Health Officer No. 10

District File Number 8-43-1277

Date Filed NOV 10 1943

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 Archie W. Wade

Licensed Embalmer No. 3037

P. O. Address Green City, 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.