

FILED OCT 5 - 1943

Registration District No. 138

Primary Registration District No. 5-5-2-1

Registrar's No. 3

1. PLACE OF DEATH:

(a) County HICKORY  
(b) City or town HERMITAGE Center Tenn  
(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) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community 6 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County HICKORY 043  
(c) City or town HERMITAGE  
(If outside city or town limits, write "RURAL")  
(d) Street No. NONE  
(If rural, give location)  
(e) Citizen of foreign country? NO (Yes or No)  
If yes, name country D

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month AUGUST day 29  
year 1943 hour 3 minute 40 P. M.  
21. I hereby certify that I attended the deceased from Feb 1  
1940 to Aug 29 1943  
that I last saw him alive on Aug 29 1943  
and that death occurred on the date and hour stated above.

Immediate cause of death:  
Pulmonary Edema 1 mo.  
Due to Metastatic neoplasm 1.0 yrs.

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_  
23. Signature Paul H. Bailey (M.D. or other) \_\_\_\_\_  
Address Hermitage Tenn Date Aug 30

3. (a) PRINT FULL NAME RAYMOND LAWRENCE RAY

3. (b) If veteran, name war NO 3. (c) Social Security No. NO

4. Sex MALE 0 5. Color or race W  
6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CORA L RAY 6. (c) Age of husband or wife if alive 51 years

7. Birth date of deceased. OCT. 8 1880  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
62 10 21 hr. min.

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

10. Usual occupation MISSIONARY

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

12. Name UNKNOWN 9

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

14. Maiden name UNKNOWN 9

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

16. (a) Informant CORA L RAY

(b) Address HERMITAGE MO

17. (a) HOSPITAL (b) Date thereof AUG. 31-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation HERMITAGE CEMETRY

18. (a) Signature of funeral director GILBERT HATHAWAY

(b) Address WHEATLAND, MISSOURI  
19. (a) Sept 2-1943 (b) Mary E. Carlstrom  
(Date received local registrar) (Registrar's signature)

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

73 00

RECEIVED

DEPT. OF HEALTH Officer No: 71

9-43-956

10-4-43

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

*Chas. Albert Hethaway*

Licensed Embalmer No. *4267*

P. O. Address

*Tellico, Md*

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.