

No. 2
4-41
17-39
X29484

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1892

State File No.

FILED FEB 8 1944
Registration District No. 8/1944

Primary Registration District No. 5003

Registrar's No. 5

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Rural - Morrow
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
on farm near Green Castle
(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
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 no

3. (a) PRINT FULL NAME JAMES BARTON RAY

3. (b) If veteran, name war no

3. (c) Social Security No. no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 8
year 1944 hour..... minute..... M.

4. Sex M

5. Color or race W

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

6. (b) Name of husband or wife Mary

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

7. Birth date of deceased 2 17 1858
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from Jan 2 1944 to Jan 2 1944;
that I last saw him alive on Jan 2 1944;
and that death occurred on the date and hour stated above;

Immediate cause of death Pneumonia Duration

8. AGE: Years Months Days If less than one day

85 10 21 ..hr.min.

Due to Influenza

Due to Infirmities of age

Other conditions Blind + almost deaf
(Include pregnancy within 3 months of death)

MOTHER FATHER

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

10. Usual occupation Farmer

11. Industry or business.....

12. Name Wm Ray

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

14. Maiden name Nannal Phillips

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

PHYSICIAN

Major findings:
Of operations..... 33a

Of autopsy.....

16. (a) Informant Gliese Daniel

(b) Address Green Castle

17. (a) Burial (b) Date thereof 1-9-1944
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Union Cemetery

18. (g) Signature of funeral director Glen E. Kent & Son

(b) Address Green City Mo

19. (a) 1/11/44 (b) Mr. J. L. Wagner
(Date received local registrar) (Registrar's signature)

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 J. S. Gachwiler M.D. (M. D. or other)
Address Nowager Mo Date signed 1/8/44

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

RECEIVED

District Health Officer No. 10

District File Number 2-44-291

Date Filed FEB 5 1944

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.....

not embalmed

....., Registered Apprentice No.

working under my personal supervision.

Signed *Glenn E. Kent*

Licensed Embalmer No. 1769

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.