

FILED OCT 13 1944

Registration District No. \_\_\_\_\_

Primary Registration District No. 5466

1. PLACE OF DEATH:

(a) County GREENE  
(b) City or town RURAL, S. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: OZARK OSTEOPATHIC HOSPITAL  
(If not in hospital or institution, write street number and location)  
(d) Length of stay: In hospital or institution 4 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Janey  
(c) City or town Kirbyville, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. Rural Route (Star)  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Donald Leroy Ray

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Baby  
6. (b) Name of husband or wife None 6. (c) Age of husband or wife if alive XX years  
7. Birth date of deceased Sept 7, 1944  
(Month) (Day) (Year)

8. AGE: Years 0 Months 0 Days 20 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation INFANT

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

MOTHER FATHER { 12. Name Earl Allen Ray  
13. Birthplace Appleton City, Mo.  
(City, town, or county) (State or foreign country)  
14. Maiden name VATERIA DAVINA  
15. Birthplace Columbus Indiana  
(City, town, or county) (State or foreign country)

16. (a) Informant MOTHER aka Mrs. Ray  
(b) Address Kirbyville, Mo.

17. (a) Burial (b) Date thereof 9-28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prayer Cove Buried by father

18. (a) Signature of funeral director Family disposal - E.A. Ray

(b) Address Kirbyville, Mo.

19. (a) 9-27-44 (b) W. H. Hensley  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 27, year 1944 hour 3:23 minute A. M.  
21. I hereby certify that I attended the deceased from Sept 23/44 to Sept 27, 1944  
that I last saw him alive on Sept 27, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Due to plyloric stenosis  
Due to congenital  
Other conditions \_\_\_\_\_  
(Include pregnancy within 5 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?  
\_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (e) Years of injury \_\_\_\_\_

23. Signature William J. Hensley M.D. or other \_\_\_\_\_  
Address 2100 S. Galloupe Springfield Mo. signed Sept 27/44

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

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**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.....

P. O. Address.....

**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.**

*X*