

No. 2
-8-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

26229

FILED AUG 21 1946

State File No. _____

Registration District No. 20

Primary Registration District No. 4031

Registrar's No. 22

1. PLACE OF DEATH:

(a) County Bates

(b) City or town Adrian
(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 years, months or days)

In this community 79 Years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bates 7

(c) City or town Adrian 1
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location) 0

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME Ida Belle Ray

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Filander Pinkney Ray 6. (c) Age of husband or wife if alive 84 years

7. Birth date of deceased June 2 1866
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 15 year 1946 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from Aug. 10 1946 to Aug. 14 1946
that I last saw her alive on Aug. 14 and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>80</u>	<u>2</u>	<u>13</u>	hr. _____ min.

Immediate cause of death Intestinal obstruction

Duration _____

9. Birthplace Terrhaute Indiana
(City, town, or county) (State or foreign country)

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) _____

10. Usual occupation Housewife

11. Industry or business _____

Major findings: Of operations _____

Of autopsy _____

MOTHER FATHER

12. Name Jim Ralston

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

14. Maiden name Elizabeth McClellan

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

16. (a) Informant Roy Ray

(b) Address Adrian Mo.

22. If death was due to external causes, fill in the following:

17. (a) Burial (b) Date thereof 8-18-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crescent Hill Cem/

(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? _____

18. (c) Signature of funeral director Ernest A. Ray

(b) Address Adrian Mo.

19. (a) Aug 17-1946 (b) Myra Owens
(Date received local registrar) (Registrar's signature)

(Specify type of place)

While at work? _____ (a) Means of injury _____

23. Signature E. E. Robinson (M. D. or other) 0

Address Adrian, Mo. Date signed 8-18-46

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

20073

RECEIVED

Dis. Officer No. 71

7-46-860

Date 8-20-46

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..... *L. H. Liff*

Licensed Embalmer No. *3650*

P. O. Address *Adrian 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.

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1. PLACE OF DEATH:

(a) County Bates
(b) City or town Adrian
(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 Jda B. Ray

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____

7. Birth date of deceased _____ (Month) _____ (Day) _____ (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

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 _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (Date received local registrar) (b) _____ (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 _____ Day _____ Year 1946 Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration

possible indignancy
Due to _____

Due to _____

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

Major findings: Of operations _____

Of autopsy none

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) (c) Means of injury _____

23. Signature Ed. Robinson (M. D. or other) _____

Address Adrian, Mo. Date signed 8-27-46

SUPPLEMENTARY

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

25075

20229