

FILED FEB 10 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1380

BIRTH NO. <u>15981-51</u>		REG. DIST. NO. <u>149</u>		PRIMARY REG. DIST. NO. <u>1002</u>		Registrar's No. <u>991</u>	
1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>JACKSON</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		c. LENGTH OF STAY (in this place) <u>life</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Kansas City</u>		d. STREET ADDRESS (If rural, give location) <u>2630 MONROE</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Lakeside Hospital</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan 18, 1951</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Jerry Alvin</u>		b. (Middle) <u>WRAY</u>		c. (Last) <u>WRAY</u>		5. SEX <u>MALE</u>	
6. COLOR OF RACE <u>WHITE</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>NEVER MARRIED</u>		8. DATE OF BIRTH <u>Jan 17, 1951</u>		9. AGE (In years last birthday) IF UNDER 1 YEAR Months <u>1</u> Days <u>12</u> IF UNDER 2 HRS. Hours <u>12</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Robert William Wray</u>		13b. MOTHER'S MAIDEN NAME <u>Dorothy Mae Moore</u>		14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Robert W. Wray, 2630 Monroe</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Respiratory & Cardiac failure</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Congenital heart</u> DUE TO (c) <u> </u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>7544</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 17, 1951</u> , to <u>Jan 18, 1951</u> , that I last saw the deceased alive on <u>Jan 17, 1951</u> , and that death occurred at <u> </u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u>Arthur L. Arbery</u> (Degree or title)				23b. ADDRESS <u>2390 1/2 Indiana</u>		23c. DATE SIGNED <u>1/18/51</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVED</u>		24b. DATE <u>1-19-51</u>		24c. NAME OF CEMETERY OR CREMATORY <u> </u>		24d. LOCATION (City, town, or county) (State) <u>Viola Ark</u>	
DATE REC'D BY LOCAL REG. <u>1-19-51</u>		REGISTRAR'S SIGNATURE <u>Sheraldine Holmes</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John P. Pugh</u>		ADDRESS <u>K.C. Mo.</u>	

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

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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed *John P. Shiel*

Licensed Embalmer No. *3625*

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.