

Health,  
& Welfare  
Public  
Service

FILED NOV 26 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-039384

STATE FILE NUMBER

Registration District No. 098 Primary Registration District No. \_\_\_\_\_ Registrar's No. 105

1. PLACE OF DEATH a. COUNTY <u>Davæes</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Davies</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Near Pattonburg</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <u>McFall, Mo.</u> <u>0310</u> Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>N.W. of Pattonburg</u>		Length of stay in 1b <u>2 years</u>	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Manuel</u> Last <u>Ray</u>			4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-14-1873</u>	9. AGE (In years last birthday) <u>85</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>6</u> Hours <u>    </u> Min. <u>    </u>	IF UNDER 24 HRS. Hours <u>    </u> Min. <u>    </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Farming</u>		11. BIRTHPLACE (City and state or country) <u>Clay County, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>
13a. FATHER'S NAME <u>Benjamin Ray</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Bigelow Ray</u>		14. NAME OF HUSBAND OR WIFE <u>Nettie C. Ray</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Franklin M. Ray</u>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia colon</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>1538</u>		
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>1538</u>		

20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. CITY, TOWN, OR LOCATION <u>Albany MO</u>	COUNTY <u>Albany MO</u>	STATE <u>Albany MO</u>
21. I attended the deceased from <u>3/31/58</u> to <u>11/20/58</u> and last saw her alive on <u>8/1/58</u> Death occurred at _____ m on the date stated above; and to the best of my knowledge, from the causes stated.				
22a. SIGNATURE <u>E. M. Lunday MD</u>		22b. ADDRESS <u>Albany MO</u>		22c. DATE SIGNED <u>8/20/58</u>

23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>11-22-1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>New Friendship</u>	23d. LOCATION (City, town, or county) (State) <u>Gentry County Missouri</u>
24. FUNERAL DIRECTOR <u>Clifford Brooks Albany, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>24 Nov. 1958</u>	26. REGISTRAR'S SIGNATURE <u>Duque Mengelhart</u>

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

300  
1-57

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 .....me....., Student Embalmer No. .... working under my personal supervision.

Student .....  
Signature of Student Embalmer

Signed .....Donald E. Coehly.....

Licensed Embalmer No. ....4868.....

P. O. Address...Albany, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.