V. S. No. 2
00M—5-43
Rev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

# THE STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 36550

FILED NOV 28 1945

Registration District No. ____ Primary Registration District No. 4024 Registrar's No. 60

**1. PLACE OF DEATH:**
(a) County J. BARRY
(b) City or town CASSVILLE
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: BARRY CO. CLINIC ()
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution two weeks. (Specify whether years, months or days)
In this community life

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Mo. (b) County BARRY
(c) City or town CASSVILLE
(If outside city or town limits, write "RURAL")
(d) Street No. ____ (If rural, give location) ()
(e) Citizen of foreign country? no (Yes or No)
If yes, name country ____

**3. (a) PRINT FULL NAME** JENNIE 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 W 21

6. (b) Name of husband or wife Chas. Ray
6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Jan. 21 1868 (Month) (Day) (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | 11 | ____ hr. ____ min. |

9. Birthplace Barry Co. Mo. (City, town, or county) O (State or foreign country)
10. Usual occupation house wife, publisher
11. Industry or business newspaper

**MOTHER FATHER**
12. Name D. P. Farris
13. Birthplace Tenn. (City, town, or county) / (State or foreign country)
14. Maiden name Comunbia Mason
15. Birthplace ARK. (City, town, or county) / (State or foreign country)

16. (a) Informant John Ray
(b) Address Cassville, Mo.
17. (a) burial (Burial, cremation, or removal) (b) Date thereof 10/5/45 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Hill Cem.
18. (a) Signature of funeral director W. H. Koon
(b) Address Cassville, Mo.
19. (a) Oct 13-1945 (Date received local registrar) (b) grace williams (Registrar's signature)

## MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month Oct. day 2 year ____ hour 4: minute 45 P. M.
21. I hereby certify that I attended the deceased from Sept 17, 1945 to Oct. 2, 1945 that I last saw her alive on Oct. 2, 1945; and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Uremia | 5 days |
| Due to Cancer of Liver (Acute) | |
| Due to ____ | |
| Other conditions (Include pregnancy within 3 months of death) ____ | |
| Major findings: Of operations ____ | |
| Of autopsy ____ | |

**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? ____ (Specify type of place)
While at work? ____ (e) Means of injury ____

23. Signature Dan Newman (M. D.)
Address Cassville, Mo Date signed 10-11-45

10-11 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6,
District File Number 1145-1138
Date Filed NOV 17 1945

## 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 E. M. Jones

Licensed Embalmer No. 3453

P. O. Address CASSVILLE, 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.**