

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

33000

1. PLACE OF DEATH

County Clay
Township Fishing River
City Excelsior Springs, Mo.

Registration District No. 198
Primary Registration District No. 3011

File No. _____
Registered No. 135
St. _____ Ward _____

2. FULL NAME CARNS, Ray H.

(a) Residence. No. U.S.V.H. #99, Ex. Springs, Mo. Ward. Toronto, Kansas
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 110 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Mrs. Ruth Carns

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb. 7, 1901

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	26	9	16	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Kansas
(STATE OR COUNTRY)

PARENTS

10. NAME OF FATHER John William Carns

11. BIRTHPLACE OF FATHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Emma Alice Simpson

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) not known
(STATE OR COUNTRY)

14. INFORMANT Deceased-Hospital record
(Address) Toronto, Kansas.

15. FILED 11/24 19 27 J. D. Craven
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov. 23, 19 27

17. I HEREBY CERTIFY, That I attended deceased from Aug. 27
5, 1927, 1927, to Nov. 23, 1927
that I last saw h. im. alive on Nov. 23, 1927, and that death occurred, on the date stated above, at 5:30 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Valvular heart disease with decompensation.

CONTRIBUTORY (SECONDARY) 921
925 (duration) 1 yrs. 9 mos. ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH, not known

DID AN OPERATION PRECEDE DEATH? no DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Clinical and laboratory

(Signed) J. A. Howell, M. D.
, 19 (Address) Excelsior Springs, Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL <u>Toronto Kansas</u>	DATE OF BURIAL <u>Nov 27 1927</u>
20. UNDERTAKER <u>Herbert Hope</u>	ADDRESS <u>Ex. Springs, Mo.</u>

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

W. F. B.