

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

Do not use this space.

36790

1. PLACE OF DEATH

County Jackson Registration District No. 399 File No. _____
 Township Caro Primary Registration District No. 100 Registered No. 4007
 City Kansas City (No. General Hospital) St. _____ Ward _____

2. FULL NAME

Ray H. Waring
 (a) Residence No. 13400 Delhamd Road St. _____ Ward _____
 (Usual place of abode) (If nonresident give city or town and State)
 Length of residence in city or town where death occurred yrs. mos. 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 OR (OR) WIFE OF Mrs. Ella Waring

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan. 15, 1883

7. AGE: YEARS 44 MONTHS 10 DAYS 19 If LESS than 1 day, hrs. or min.

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work Manager Ucasia
 (b) General nature of industry, business, or establishment in which employed (or employer) Mutual Life Ins.
 (c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Leeward (STATE OR COUNTRY) Me.

10. NAME OF FATHER H. M. Waring

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Pa

12. MAIDEN NAME OF MOTHER Ella Kimball

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pa

14. INFORMANT (Address) Mollie Waring P. 3400 Delhamd Rd.

15. FILED 12/5-27 1927 M. M. Crewe REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1927

17. I HEREBY CERTIFY That I attended deceased from _____, 19____, to _____, 19____, that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
1860
multiple fracture - pelvis
from 10 ft. story & building
 (duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (SECONDARY) !!
 (duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH: _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? Autopsy
 (Signed) Paul J. ... M. D.

1915, 1927 (Address) Liberty Corner

*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 Forest Hill DATE OF BURIAL 12-6 1927

20. UNDERTAKER Whitney Sons ADDRESS City

N. B.—Every citizen should state CAUSE OF DEATH. This information is very important.

NOV 14 1957

**MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH**

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH

County Jackson
Township _____
City K. City (No. _____)

Registration District No. 399
Primary Registration District No. 1882

File No. _____
Registered No. 4607
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St., _____ Ward. _____
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>m</u>	4. COLOR OR RACE <u>w</u>	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) <u>m</u>
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5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

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

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
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8. OCCUPATION OF DECEASED

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

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

10. NAME OF FATHER _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER _____

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

14.

INFORMANT _____
(Address)

FILED 175.127 11.27.1927 M. D. Crowe
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 4 1927

17. I HEREBY CERTIFY that I attended deceased from _____, 19____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, of _____.

THE CAUSE OF DEATH WAS AS FOLLOWS:
transpiration. Multiple injuries. Fell from 10th story of building

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH: _____
DID AN OPERATION PRECEDE DEATH? no DATE OF _____
WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) Henry G. Gough, M. D.
, 19____ (Address) shelby brown

*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 _____ DATE OF BURIAL _____

20. UNDERTAKER _____ ADDRESS _____

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated FULLY. PHYSICIAN'S should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRATION IS COMPLETE UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

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