

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

Do not use this space.

7417

30

1. PLACE OF DEATH

County Scott

Registration District No. 821

File No. 30

Township Sibester

Primary Registration District No. 4553

Registered No. _____

City Sibester (No. _____)

St. _____ Ward _____

2. FULL NAME

Harold Derssey Ray

(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

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Infant

5A. If MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

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

July-18-1927

7. AGE

YEARS

MONTHS

DAYS

If LESS than 1 day, _____ hrs. or _____ min.

7

10

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)

Sibester

(STATE OR COUNTRY)

Mo

10. NAME OF FATHER

Harold Ray

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

Indiana

12. MAIDEN NAME OF MOTHER

Irma Porter

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

Missouri

14. INFORMANT

(Address)

Harold Ray
Sibester, Mo.

15. FILE

No. _____

19 _____

4/4 28 St G Derris

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb. 28 - 1928

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1928, to Feb. 28, 1928, that I last saw him alive on Feb. 27, 1928, and that death occurred, on the date stated above, at 4:10 9 min.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Broncho-Pneumonia

CONTRIBUTORY (SECONDARY) Whooping Cough

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH, _____

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____

(Signed) Geo. H. Russell, M. D.

2/28, 1928 (Address) Sibester, 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

Memorial Park -

DATE OF BURIAL

2/29 1928

20. UNDERTAKER

G A Sumpster

ADDRESS

Sibester Mo

No. 21—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.

U.S. NO. 1