

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

Do not use this space.

20306

1. PLACE OF DEATH
 County Franklin Registration District No. 287 File No. _____
 Township Clay Primary Registration District No. N 401 Registered No. _____
 City _____ (No. _____) St. _____ Ward _____

2. FULL NAME Leta 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 Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) _____

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.
1 3 25

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 _____

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1928

17. I HEREBY CERTIFY That I attended deceased from June 7 1928 to June 14 1928 that I last saw her alive on June 13 1928 and that death occurred, on the date stated above, at 6 a m.

THE CAUSE OF DEATH WAS AS FOLLOWS:
Acute Colitis

119B (duration) yrs. mos. 7 ds.

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

18. WHERE WAS DISEASE CONTRACTED
 IF NOT AT PLACE OF DEATH? No

19. DID AN OPERATION PRECEDE DEATH? No DATE OF _____

20. WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Stages
 (Signed) E. J. Case, M. D.
7-14-28 (Address) Hammersville

*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.

9. BIRTHPLACE (CITY OR TOWN) _____ (STATE OR COUNTRY) Dunklin Co. Mo.

10. NAME OF FATHER Walter Ray

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

12. MAIDEN NAME OF MOTHER Ethel Danicko

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

14. INFORMANT H. W. Hays (Address) Marmaduk Ark.

15. FILED _____ 19 _____ REGISTRAR _____

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Sitonsdale Cemetery DATE OF BURIAL 7/15 1928

20. UNDERTAKER Biggs H. H. Hays Co. ADDRESS Cardwell Mo.

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.

**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 Dunklin Registration District No. 287 File No.
 Township Clay Primary Registration District No. 3403- Registered No. W 3
 City..... (No.....) St. Ward.....

2. FULL NAME Lula 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Feb - 11 1927

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	<u>1</u>	<u>3</u>	<u>25</u>	

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.....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 14 1928

17. I HEREBY CERTIFY That I attended deceased from June 11 1928, to June 14 1928
 (but I last saw her alive on June 13 1928, and that death occurred, on the date stated above, at 6 a m.)

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Acute Colitis

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? No
 WHAT TEST CONFIRMED DIAGNOSIS Wagne
 (Signed) E. G. Cope, M. D.
 , 19 28 (Address) Hornesville

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Dunklin Mo

10. NAME OF FATHER Walter Ray

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

12. MAIDEN NAME OF MOTHER Ethel Davidson

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

14. INFORMANT H. W. Hayward
 #9 (Address) Marionette Ark.

15. FILED 8-10-24 E. G. Cope REGISTRAR

19. PLACE OF BURIAL, CREMATION, OR REMOVAL DATE OF BURIAL
Silverdale Cemetery 7/15 1928

20. UNDERTAKER ADDRESS
Riggs, Hdw & Grng Co Cardwell

SUPPLEMENTARY

Every physician 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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE. DESCRIBED BY LAW

5-20306