

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

Do not use this space.

7541

1. PLACE OF DEATH

County Sheeps Registration District No. 677
Township Rosalia Primary Registration District No. 4403
City Edward Ray (No. _____) St. _____ Ward _____

File No. _____
Registered No. 16
St. _____ Ward _____

2. FULL NAME

(a) Residence. No. _____ St. _____ Ward _____
(Usual place of abode)

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. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 MEDICAL CERTIFICATE OF DEATH

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

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2 1929

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

I HEREBY CERTIFY, That I attended deceased in an emergency in _____, to Feb 2, 1929, that I last saw him alive on Feb 2, 1929, and that death occurred, on the date stated above, at 4:30 P.M.

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9, 1874

THE CAUSE OF DEATH* WAS AS FOLLOWS:

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
55 8 2

I saw Edward Ray in an emergency a few moments before death for first time, like heart failure.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 109 A
(c) Name of employer _____

CONTRIBUTORY (SECONDARY) Pneumonia
And "Flu"

9. BIRTHPLACE (CITY OR TOWN)

(STATE OR COUNTRY) Sheeps Agency

18. WHERE WAS DISEASE CONTRACTED

HEARD AT PLACE OF DEATH _____

10. NAME OF FATHER

Andrew Ray

DIDAL OPERATION PRECEDE DEATH _____ DATE OF _____

WAS THERE AN AUTOPSY? _____

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Iowa

WHAT TEST CONFIRMED DIAGNOSIS? _____

12. MAIDEN NAME OF MOTHER

Elizabeth Merritt

(Signed) J. D. Dore, M. D.

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Iowa

*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.

14. INFORMANT

(Address) Ernest Ray, Rosalia, Mo.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

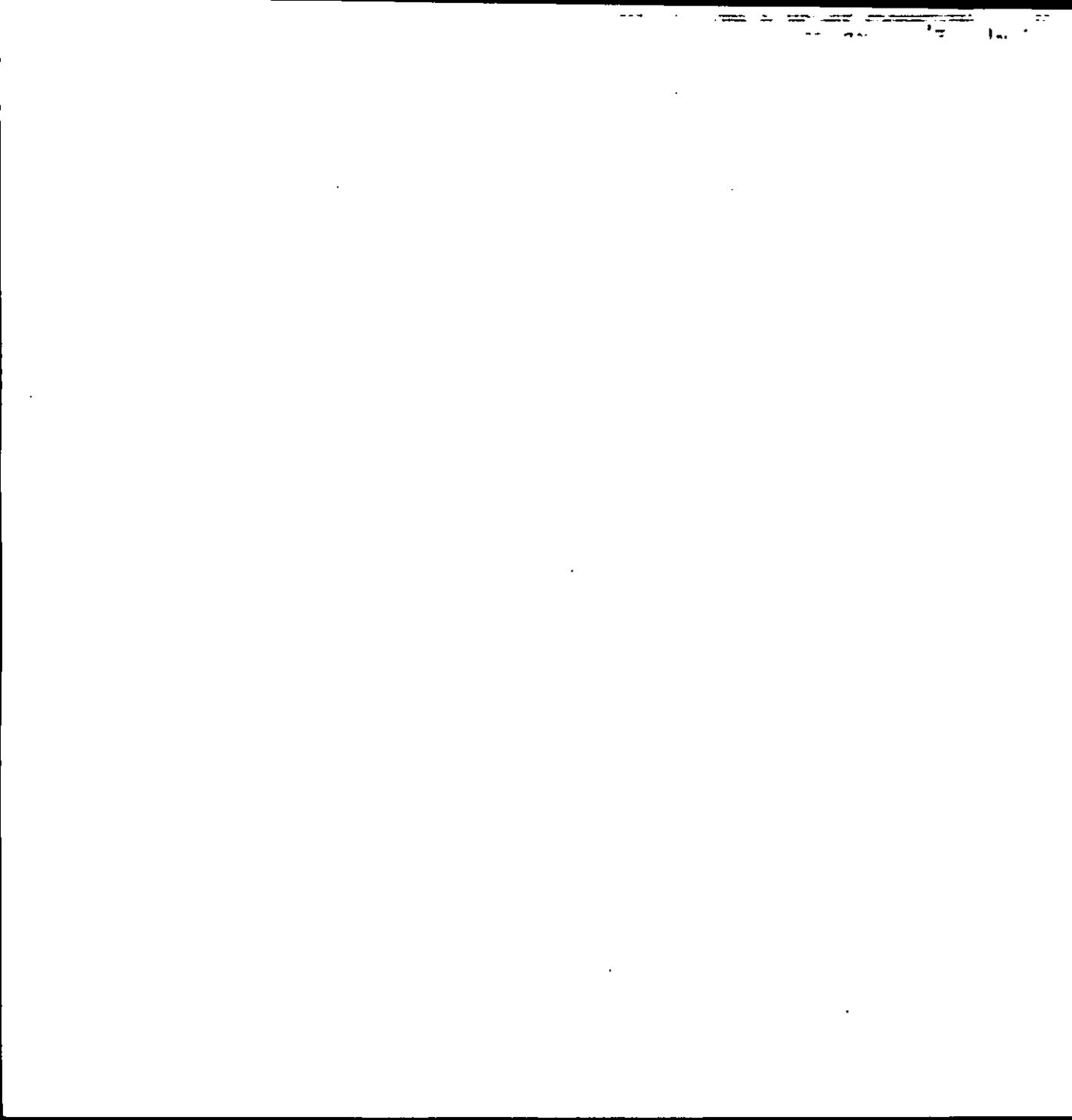
Rosalia, Mo. DATE OF BURIAL 2-4 1929

15. FILED

Feb 4, 1929 Joe F. Ryan REGISTRAR

20. UNDERTAKER

H. H. Meadows ADDRESS Rosalia, Mo.



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

ALL INFORMATION CALLED
FOR MUST BE WRITTEN ON
THIS SUPPLEMENTARY.

1. PLACE OF DEATH.

County Chelms
Township Rolla
City Rolla (No.)

Registration District No. 677
Primary Registration District No. 4403

File No.
Registered No. 16
St. Ward)

2. FULL NAME

Edward Roy

(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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) N

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) May 9, 1874

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 8 23

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work (duration) yrs. mos. ds.
(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)

15.

FILED 3/13 1929 for J. F. Ayers REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Feb 2 19 29

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

THE CAUSE OF DEATH* WAS AS FOLLOWS:

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

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed)....., M. D.
, 19 (Address)

*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

19

PARENTS

SUPPLEMENTARY

1454-S