MAY 25 1929

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

Do not use this space.

14414

1. PLACE OF DEATH
County Greene — Registration District No. 318
Township — Primary Registration District No. 2001
City Springfield (No. Springfield Baptist Hosp St. Ward)
File No.
Registered No. 339

2. FULL NAME Walter H Ray
(a) Residence. No. Forsythe Ins 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. 10 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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 10 - 1902

7. AGE: Years 26 | Months 8 | Days 9 | If LESS than 1 day, ___ hrs. or ___ min.

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)
(c) Name of employer

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

PARENTS
10. NAME OF FATHER John H Ray
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ins
12. MAIDEN NAME OF MOTHER Lynda Houseman
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Ill

14. INFORMANT John H Ray
(Address) Forsythe Ins

15. FILED 4-19, 1929 Lou Sharp REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3

16. DATE OF DEATH (MONTH, DAY AND YEAR) April 19 1929

17. I HEREBY CERTIFY, That I attended deceased from Apr 9, 1929, to Apr 19, 1929, that I last saw her alive on Apr 19, 1929, and that death occurred, on the date stated above, at 7 p m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute perforative Appendicitis (duration) yrs. mos. 15 ds.

CONTRIBUTORY (SECONDARY) General peritonitis (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? Yes DATE OF Apr 9 1929
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) Robert Glynn, M. D
4/19/29 19 (Address) Springfield 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: Forsythe Ins
DATE OF BURIAL: April 21 1929

20. UNDERTAKER: J W Klingner & Co Springfield Mo
ADDRESS

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

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.

237

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