

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

Do not use this space.

35910

1. PLACE OF DEATH

County.....
Township.....
City.....

Registration District No. 791
Primary Registration District No. City Hospital #2

File No.....
Registered No. 10720
St. Ward)

2. FULL NAME

Ray, McDonald
(a) Residence No. 1047 N. Whittier Ward. 11
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. 4 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE col. 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) wid.

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 9-20-1880

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
49 - 1 + 8

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Porter
(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) Ky

10. NAME OF FATHER unknown

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

12. MAIDEN NAME OF MOTHER unknown

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

14. INFORMANT A. Gertrude Creath
(Address) City Hospital #2

15. W. S. Wade
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 10/28/1929

17. I HEREBY CERTIFY, That I attended deceased from 10-28-1929 to 10-28-1929, that I last saw him alive on 10-28-1929 and that death occurred, on the date stated above, at 6 P.M. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
930
Chronic myocarditis
(duration) - yrs. 6 mos. - ds.

CONTRIBUTORY (SECONDARY) 905
(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? clinical
(Signed) A. E. Hale, M. D.

10/31/1929 (Address) City Hosp #2

*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 Guthrie Ky. DATE OF BURIAL 11-1 1929

20. UNDERTAKER W. S. Wade ADDRESS 4202 Finney

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.

25
2
3

FILED

REGISTRAR

