

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

Do not use this space.

20169
7

1. PLACE OF DEATH
 County Goddard Registration District No. 5823
 Township Lincoln Primary Registration District No. 621
 City (No. St. Ward)

2. FULL NAME Glen Marley Ray
 (a) Residence. No. St. Ward. (If nonresident, give city or town and State)
 Length of residence in city or town where death occurred yrs 30 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) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) January 19 1900

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
30 5 7

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)
 (c) Name of employer

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

10. NAME OF FATHER George W Ray

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

12. MAIDEN NAME OF MOTHER
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Rebekah Butts
 (STATE OR COUNTRY) Verona Council Mo.

14. INFORMANT Lizzie Hudson
 (Address) 139 Washington Jet Mo.

15. FILED July 26 1930 Blair D Harn REGISTRAR
July 5-30 C. P. Fryer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 1930

17. I HEREBY CERTIFY, That I attended deceased from April 19 1930, 1930 to June 25 1930 that I last saw him alive on June 25 1930 and that death occurred, on the date stated above, at 11 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
metastatic carcinoma
epithelioma
52 basal cell type
5302 (duration) 5 yrs. mos. ds.
 CONTRIBUTORY (SECONDARY) Pneumonia
 (duration) 2 1/2 yrs. 1 mos. 3 ds.

18. WHERE WAS DISEASE CONTRACTED
 3 IF NOT AT PLACE OF DEATH. not known

DID AN OPERATION PRECEDE DEATH? yes DATE OF July 6 1926

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS laboratory
 (Signed) J. A. Hyatt, M. D.
 , 19 (Address) Elmo

*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 Lomas Cemetery DATE OF BURIAL June 27 1930

20. UNDERTAKER Price & Harn ADDRESS Elmo 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.

JUL 29 1930

**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 Holaway
Township Lincoln
City..... (No.....)..... St..... Ward)

Registration District No. 621
Primary Registration District No. 3-823

File No. 7
Registered No.

2. FULL NAME

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

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.

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) (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 Aug 29, 1930 Clair D. Hunt REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) June 25 - 1930

17. I HEREBY CERTIFY That I attended deceased from 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:

metastatic carcinoma and epithelioma of Bridge of Nose
(duration)..... yrs. mos. da.

CONTRIBUTORY (SECONDARY) relapsing which
(duration)..... yrs. mos. da.

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

Every item of information should be carefully supplied. AGE should be so exactly. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Brief statement of OCCUPATION is very important. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

SUPPLEMENTARY

5-20169