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.

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

Do not use this space.

File No. 41875

Registered No.

1. PLACE OF DEATH

County Worth

Township West Union

City Parnell (No. .... St. .... Ward)

Registration District No. 904

Primary Registration District No. 6215

2. FULL NAME Henry 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	W	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct 1, 1874

7. AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56	2	13	

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) Isadorah (STATE OR COUNTRY) Mo.

PARENTS

10. NAME OF FATHER W. B. Ray

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

12. MAIDEN NAME OF MOTHER Elizabeth Round

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

14. INFORMANT Mrs. Cora Ray (Address) Parnell, Mo.

15. FILED .... 19 .... REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1930

17. I HEREBY CERTIFY, That I attended deceased from April, 1928, to Dec 14, 1930 that I last saw him alive on Dec 12, 1930 and that death occurred, on the date stated above, at 4:30 p.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Carcinoma - [illegible] and eye region

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) 49

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED ✓

IF NOT AT PLACE OF DEATH

DID AN OPERATION PRECEDE DEATH? Yes DATE June 1928, Aug 1929, Date 1930

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? [illegible]

(Signed) E. J. Rose, M. D.

, 19 (Address) Grant City 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	DATE OF BURIAL
Isadorah Cemetery	12/16 1930

20. UNDERTAKER	ADDRESS
Arch C Dunfee	Grant City

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 Worth Registration District No. 904 File No.
Township. W Union Primary Registration District No. 6215 Registered No.
City (No. , St. Ward)

2. FULL NAME Henry Ray

(a) Residence. No. St., Ward. (If nonresident give city or town and State)
(Usual place of abode)

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

PARENTS

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 Mrs Cora Ray
(Address) Parnell Mo

15. FILED 12/16, 1930 F. L. Johnson
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Dec 14 1930

17. I HEREBY CERTIFY, That I attended deceased from /, 19, 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:

(duration) yrs. mos. ds.

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
Isadora Mo	12/16 1930
20. UNDERTAKER	ADDRESS
Arch Dunfee	Grant City

SUPPLEMENTARY

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.
REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

S-41875