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

Do not use this space.

1. PLACE OF DEATH

County Jackson — Registration District No. 388 — File No. 31193

Township Kaw — Primary Registration District No. 3004 — Registered No. 3688

City K.C. Mo. (No. St. Joseph Hospital St. ..... Ward)

2. FULL NAME Ray Muir

(a) Residence. No. 5527 Bonita St., 14 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)
Male	White	Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug-24-1894

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	37	0	9	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(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) Mo.

PARENTS

10. NAME OF FATHER Elbia Muir

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

12. MAIDEN NAME OF MOTHER Lena Bowen

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

14. INFORMANT Mrs. Eliz. Muir

(Address) 5527 Bonita Ave

9/3 1931 M. M. Crowe REGISTRAR

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MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept-3-1931

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1931, to Sept 2nd, 1931 that I last saw him alive on Sept 2nd, 1931, and that death occurred, on the date stated above, at 1 AM m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Peritonitis following rupture peptic ulcer

117

129

about (duration) 2 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Chronic peptic ulcer

(duration) 5-7 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH Unknown

DID AN OPERATION PRECEDE DEATH? No. DATE OF

WAS THERE AN AUTOPSY? Refused

WHAT TEST CONFIRMED DIAGNOSIS? Routine Laboratory + Xray

(Signed) R. F. Pittam, M. D.

9/3, 1931 (Address) 830 Professional Bldg.

*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
Mt. Hope	9-5-1931
20. UNDERTAKER	**ADDRESS**
Mrs. C. L. Forster	K.C. Mo.

very item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

Staff Professional
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