

MAR 28 1933

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
See W.P. Patterson
5419

1. PLACE OF DEATH *Home*
 County *Franklin* Registration District No. *318*
 Township *16307 clay* Primary Registration District No. *2001*
 File No. _____ Registered No. *183*
 St. _____ Ward) _____

2. FULL NAME *Ray Carson*
 (a) Residence, No. _____ St. _____ Ward. _____
 (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. _____
 (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*
 (Write the word)

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 16 - 1853*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. or _____ min.
79 10 9

OCCUPATION
 8. Trade, profession, or particular kind of work done, as *Carpenter*
 sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

FATHER
 13. NAME *Wm P Carson*
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

MOTHER
 15. NAME *Mrs E Carson*
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Mo*

17. INFORMANT (ADDRESS) *Ray Carson*
Springfield, Mo

18. BURIAL, CREMATION, OR REMOVAL PLACE *Wyle Park* DATE *2/27* 19*33*

19. UNDERTAKER (ADDRESS) *Wm W. H. ...*

20. FILED *7-57* 1933 *Ralph W. Hampton Registrar*

3 MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *Feb. 25* 19*33*

I HEREBY CERTIFY That I attended deceased from *Feb. 15* 19*33*, to *Feb. 25* 19*33*

I last saw him alive on *Feb. 25* 19*33* Death is said to have occurred on the date stated above, at *10 P* m.
 The principal cause of death and related causes of importance were as follows:
Uræmia
157
1320
 Other contributory causes of importance:
Prostatic Hypertrophy
Atherosclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? *Clinical* Was there an autopsy? *no*

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? *no*
 If so, specify _____
 (Signed) *W. P. Patterson*, M. D.
 (Address) *Springfield, Mo.*

