

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

Do not use this space.

FEB 18 1936

812

1. PLACE OF DEATH

County Franklin Registration District No. 286
 Township Franklin Primary Registration District No. 5464
 City Keosauqua, Mo. (No. _____) St. _____ Ward _____

File No. _____
 Registered No. _____

2. FULL NAME

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 6 - 1869

7. AGE YEARS MONTHS DAYS If LESS than 1 day,hrs. ormin.
67 - 7da

8. Trade, profession, or particular kind of work done, as spinner, 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

13. NAME Wm Ray

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

15. MAIDEN NAME Don't know

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo

17. INFORMANT Paul Weaver
 (ADDRESS) Keosauqua, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Liberty DATE 1-15 1936

19. UNDERTAKER Franklin Undertaking Co
 (ADDRESS) Keosauqua, Mo.

20. FILED Feb 3 1936 Thelma Doves
 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-13 1936

22. I HEREBY CERTIFY, That I attended deceased from 1-12, 1936, to 1-13, 1936

I last saw her alive on 1-13, 1936 Death is said to have occurred on the date stated above, at 12:45 P.m.

The principal cause of death and related causes of importance were as follows:

Meningitis - type not determined.
 Other contributory causes of importance: None

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____
 If so, specify _____

(Signed) J. H. Skerrin, M. D.
 (Address) Keosauqua, 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.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

