

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

40098
Do not use this space.

DEC 21 1938

1. PLACE OF DEATH

(a) County Claske Registration District No. 711

(b) Township Union Primary Registration District No. 5940

(c) City _____ (d) Street No. _____ St.

(e) Length of residence in city or town where death occurred _____ yrs. mos. ds. (f) How long in U. S., if of foreign birth? _____ yrs. mos. ds.

2. PRINT FULL NAME Mourad Ray

(a) Residence, No. _____ St. (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 (write the word) widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 4-14-1851

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>87</u>	<u>16</u>	<u>23</u>	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 11-7, 1938

22. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1937, to Nov 5-, 1938

I last saw him alive on Nov 5-, 1938. Death is said to have occurred on the date stated above, at _____ m.

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

Mitral Stenosis Date of onset _____

Age

Other contributory causes of importance: _____

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

13. NAME Bill Ray

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

15. MAIDEN NAME Warriek Foster

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

17. INFORMANT (ADDRESS) Bea Ray Dixon Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Fox Crossing DATE 11/9, 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Field N. Gilbert Dixon Mo.

20. FILED 11-13, 1938 A. B. Smith Local Registrar.

Name of operation _____ Date of _____

What test confirmed diagnosis? X-ray 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) A. B. Smith, M. D.

(Address) Dixon 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.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, _____

Now J

or by _____

Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Fred D. Gilman

Licensed Embalmer No. *2341*

P. O. Address. *Sixon me*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING: (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.