

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

21098
 Do not use this space.

1. PLACE OF DEATH

(a) County Johnson Registration District No. 399
 (b) Township Ham Primary Registration District No. 1002 Registered No. 2366
 (c) City Kansas City (d) Street No. Research Hosp St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (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

Robt. Gardner Dray (Toht. Gardner Dray)
 (a) Residence, No. 2640 Victor St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>male</u>	4. COLOR OR RACE <u>white</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>wife</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>L. Jean Dray</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Nov. 4, 1905</u>		
7. AGE YEARS <u>33</u>	MONTHS <u>7</u>	DAYS <u>5</u>
If LESS than 1 day, hrs. or min.		
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Pharmacist</u>		
9. Industry or business in which work was done, as saw mill, bank, etc. <u>Crown Drug Co.</u>		
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) <u>Savannah, Mo.</u>		
13. NAME <u>Wm. H. Dray</u>		
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Dissey Co., England</u>		
15. MAIDEN NAME <u>Laura Bell Sadler</u>		
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Nebraska</u>		
17. INFORMANT (ADDRESS) <u>Heator Funeral Home, St. Joseph, Mo.</u>		
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>St. Joseph, Mo.</u> DATE <u>6/10, 1939</u>		
19. FUNERAL DIRECTOR (NAME) (ADDRESS) <u>Mrs. C. L. Foster</u>		
20. FILED <u>June 8, 1939</u> <u>M. M. Crome</u> Local Registrar.		

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) June 9, 1939

22. I HEREBY CERTIFY, That I attended deceased from June 9, 1939, to June 9, 1939.
 I last saw him alive on June 9, 1939. Death is said to have occurred on the date stated above, at 10:45 p.m.
 The principal cause of death and related causes of importance were as follows:
Strangulated left inguinal hernia
peritonitis
oleus
 Date of onset 5-27-39

Other contributory causes of importance:
peritonitis
oleus
 Date of onset 5-28-39
5-28-39

Name of operation herniotomy Date of 5-27-39
 What test confirmed diagnosis? Surgery Was there an autopsy? yes

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) C. F. Hunt, M. D.
 (Address) Research Hospital

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.

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AUG 15 1942

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,

....., or by

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

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.