

JAN 22 1940

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

4159

Do not use this space.

1. PLACE OF DEATH

(a) County North Registration District No. 919
 (b) Township Witchell Primary Registration District No. 4545 Registered No. _____
 (c) City Grant City (d) Street No. _____ 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

(a) Residence, No. CORRA MAE RAY St. same
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 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 Henry Ray
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Nov. 28, 1874
 7. AGE YEARS 65 MONTHS 2 DAYS 12 If LESS than 1 day, _____ hrs. _____ min.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Did not work
 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) June 6, 1940 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) Bedford, Iowa
 (STATE OR COUNTRY) Wapawash Co., Mo.

FATHER 13. NAME Adrian Carter Caswell
 14. BIRTHPLACE (CITY OR TOWN) Jackson County
 (STATE OR COUNTRY) Ohio

MOTHER 15. MAIDEN NAME Anna E. Whelan
 16. BIRTHPLACE (CITY OR TOWN) Franklin County
 (STATE OR COUNTRY) Iowa

17. INFORMANT (ADDRESS) Velma Ray
Grant City, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Madison Co. DATE 1/11/40

19. FUNERAL DIRECTOR (NAME) Arch C. Duffer
 (ADDRESS) Grant City, Mo.

20. FILED _____ 19 _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10, 1940

22. I HEREBY CERTIFY, That I attended deceased from 1-6, 1940 to 1-10, 1940

I last saw h. c. v. alive on 1-10, 1940 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:

Cerebral Hemorrhage Date of onset _____

Other contributory causes of importance: g 2 h

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) Gentley Reah
 (Address) Grant City, Mo.

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.....

Arch C. Dunfee

Licensed Embalmer No.....

3252

P. O. Address.....

Grant City, Mo.

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.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

4159
Do not use this space.

1. PLACE OF DEATH

(a) County North Registration District No. 903
(b) Township Plotchell Primary Registration District No. 4545
(c) City Brant City (d) Street No. _____ 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

(a) Residence, No. Cora May Ray
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) wid

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

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

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
65 2 12

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

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT
(ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE

19. FUNERAL DIRECTOR
(ADDRESS)

20. FILED Mar. 21, 1940 Clifford Foss
Local Registrar

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10, 1940

22. I HEREBY CERTIFY, That I attended deceased from

I last saw him alive on _____, 19____. 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:

Date of onset

Other contributory causes of importance:

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) Bentley Neal, M. D.

(Address) Brant City

