

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **17803**

Registration District No. **29**

Primary Registration District No. **5038**

Registrar's No. **19**

1. PLACE OF DEATH:

(a) County **Barry**
(b) City or town **Cassville (Rural) Flat Creek tp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Route 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **2**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barry**
(c) City or town **Cassville (Rural)**
(If outside city or town limits, write "RURAL")
(d) Street No. **Route 1**
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

8. (a) PRINT FULL NAME **CLAUDE RAY AAR**

3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **July 18 1886**
(Month) (Day) (Year)

8. AGE: Years **53** Months **9** Days **9** If less than one day hr. _____ min. _____

9. Birthplace **Barry County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Farmer**

11. Industry or business _____

MOTHER FATHER { 12. Name **Joseph Ray**
18. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)
14. Maiden name **Addie Sills**
15. Birthplace **Unknown Kentucky**
(City, town, or county) (State or foreign country)

16. (a) Informant _____ (b) Address _____

17. (a) **Burial** (b) Date thereof **4/29/40**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Oak Hill**

18. (a) Signature of funeral director **Koon Funeral Home**
(b) Address **Cassville, Mo.**

19. (a) **5-14-40** (b) **Seawrenman**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **27**
year **1940** hour **4** minute **30 P.M.**

21. I hereby certify that I attended the deceased from **April 27 1940** to **April 27 1940**
that I last saw him alive on **April 27 1940**
and that death occurred on the date and hour stated above.

Immediate cause of death **Infectious diarrhea** Duration **1 da.**

Due to _____
Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underlines the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **30**

While at work? _____ (Specify type of place)
(e) Means of injury _____

23. Signature **Dary Marthout** (M. D. or other) **P.M.D.**
Address **Cassville, Mo.** Date signed **4-29-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

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

Signed.....
Eugene Wood

Licensed Embalmer No. *3804*

P. O. Address *Cossville, 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.