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-39
DC23159

Registration District No. **791**

Primary Registration District No.

Registrar's No. **7634**

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

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
5861 Cates Ave
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 day
6 wks (Specify whether)

In this community 6 wks
years, months or days

3. (a) PRINT FULL NAME James Monroe Ray

3. (b) If veteran, name war no.

3. (c) Social Security No. none

4. Sex male

5. Color or race white

6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife Mary

6. (c) Age of husband or wife if alive 31 years

7. Birth date of deceased: Aug (Month) 31 (Day) 1873 (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>67</u>	<u>0</u>	<u>20</u>	hr. min.

9. Birthplace White Oak Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business 0

MOTHER FATHER { 12. Name Desley Ray 9

13. Birthplace Missouri
(City, town, or county) (State or foreign country)

14. Maiden name unknown

15. Birthplace unknown
(City, town, or county) (State or foreign country)

16. (a) Informant Ruth Berry

(b) Address 922 So Kinross Highway

17. (a) removal (b) Date thereof 9-11-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rector Ark

18. (a) Signature of funeral director W. H. Irby
Rector Ark

(b) Address Rector Ark

19. (a) SEP 11 1940 (b) J. J. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Arkansas (b) County Clay

(c) City or town Rector NR
(If outside city or town limits, write "RURAL")

(d) Street No. 1
(If rural, give location)

(e) If foreign born, how long in U. S. A.? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11 year 1940 hour 930 minute 0 M.

21. I hereby certify that I attended the deceased from Sept 3rd to Sept 11th, 1940; that I last saw him alive on Sept 11th, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-pneumonia Duration 3 days

Due to General Debility (resulting from malignancy of large bowel)

Other conditions: 46
(Include pregnancy within 3 months of death)

Major findings: 46
Of operations

Of autopsy _____

PHYSICIAN
Underline 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? _____

While at work? _____ (Specify type of place) Means of injury 5

Signature Dr. Walter S. Puffer (M. D. or other) D.O.

Address 4502 S. So. Highway Date signed 9-11-40
5861 Nottingham

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 *Howard F. Rowland*

Licensed Embalmer No. *3114*

P. O. Address *St Louis 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. 20357

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 7634

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

1. PLACE OF DEATH:

(a) County: St Louis
(b) City or town: (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3861 Coles ave, Private Res.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 1 da (Specify whether
In this community: 6 wks (Specify whether
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: ark (b) County: clay
(c) City or town: Pectora (If outside city or town limits write "RURAL")
(d) Street No.: (If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: James Monroe Roy

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

4. Sex: m 5. Color or race: w 6. (a) Single, widowed, married divorced: wid

6. (b) Name of husband or wife: 6. (c) Age of husband, or wife, if alive: years

7. Birth date of deceased: (Month) (Day) (Year)

8. AGE: Years: 67 Months: 0 Days: 20 If less than one day hr min.

9. Birthplace: (City, town, or county) (State or foreign country)

10. Usual occupation:

11. Industry or business:

12. Name:

13. Birthplace: (City, town, or county) (State or foreign country)

14. Maiden name:

15. Birthplace: (City, town, or county) (State or foreign country)

16. (a) Informant:

(b) Address:

17. (a) (Burial, cremation, or removal) (b) Date thereof: (Month) (Day) (Year)

(c) Place: burial or cremation:

18. (a) Signature of funeral director:

(b) Address:

19. (a) 2-18-51 (Date received local registrar) (b) J. F. Bredeck (Registrar's signature)

19. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Sept day: 11 year: 1940 hour: minute: M.

21. I hereby certify that I attended the deceased from 19 to 19 that I last saw him alive on and that death occurred on the date and hour stated above.

Immediate cause of death:

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations:

Of autopsy:

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?

(Specify type of place) While at work? (c) Means of injury:

23. Signature: Walter R. Phipps (M. D. or other)

Address: 5815 Nottingham Ave. (City, town, or county) State signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

