No. 2
-1-10-39
-17-39
X21492

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED NOV 1 1940

791

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

1003

State File No. 34110

Registration District No. 791

Primary Registration District No. 1003

Registrar's No. 8807

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: De Pauls Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 2 (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 941 W. Webster St.
(If rural, give location)

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

3. (a) PRINT FULL NAME Nora Mavourene Ray

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race W.

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

6. (b) Name of husband or wife Curtis Ray.

6. (c) Age of husband or wife if alive 52 years

7. Birth date of deceased Dec. (Month) 29th. (Day) 1896 (Year)

8. AGE: Years 43 | Months 9 | Days 26 | If less than one day hr. min.

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

10. Usual occupation Housework 0

11. Industry or business 1

FATHER
12. Name James Edwards 0
13. Birthplace (City, town, or county) Tenn. (State or foreign country)

MOTHER
14. Maiden name Julia Holstein
15. Birthplace (City, town, or county) Mo. (State or foreign country)

16. (a) Informant Curtis Ray
(b) Address Springfield, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 10-25-40 (Month) (Day) (Year)
(c) Place: burial or cremation Springfield, Mo.

18. (a) Signature of funeral director Provost Und Co.
(b) Address 3710 N. Grand Blvd.

19. (a) OCT 25 1940 (Date received local registrar) (b) J F Budd (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 25th year 1940 hour 1.50 minute A. M.

21. I hereby certify that I attended the deceased from Sept. 28, 1940, to Oct. 25, 1940; that I last saw her alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death Acute Hemorrhagic Pancreatitis

Due to Cholecystitis - Calculous Peri Carditis -

Due to Athero sclerosis. - Hypo Static Pneumonia

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

Major findings:
Of operations 126

Of autopsy Acute Hemorrhagic Pancreatitis

Duration

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? (Specify type of place)
While at work? (e) Means of injury 1

23. Signature R. G. Hayden (M. D. or other)
Address 5899 Delmar Date signed 10/25/40.

(Licensed Embalmer's Statement on Reverse Side)

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Robert L Pinkman

Licensed Embalmer No. 3553

P. O. Address 3710 N. Grand Bl

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

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