

11-10-39
v. 5-17-39
I X2142

MAR 19 1941

Registration District No. **636**

Primary Registration District No. **6098A**

Registrar's No. **7**

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

1. PLACE OF DEATH:

(a) County **Stoddard**
(b) City or town **DEXTER**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Stoddard Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Stoddard**
(c) City, or town **Barab**
(If outside city or town limits, write "RURAL")
(d) Street No. **Dexter R R #3**
(If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **CHARLE KATHLEEN RAY**

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

4. Sex **F** 5. Color or race **W** 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 **August 27, 1940**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
5 11 hr. min.

9. Birthplace **Stoddard Co. Mo.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER
12. Name **Dolan Ray**
13. Birthplace **Stoddard Co. Mo.**
(City, town, or county) (State or foreign country)
14. Maiden name **Laura S. ...**
15. Birthplace **Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dolan Ray**

(b) Address **Dexter Mo.**

17. (a) **Burial** (b) Date thereof **Feb 8, 1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (c) Signature of funeral director **Dennis ...**

(b) Address **Paris, Mo.**

19. (a) **Feb 15, 1941** (b) **Laura Hopkins**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb** day **7** year **1941** hour **9 o'clock** minute **6** M.

21. I hereby certify that I attended the deceased from **Jan 31, 1941** to **Feb 7, 1941**; that I last saw her alive on **Feb 7, 1941**; and that death occurred on the date and hour stated above.

Immediate cause of death **Pneumonia** Duration **7 days**

Due to _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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? **at home**

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

23. Signature **T. H. Groce** (M. D. or other) **Bernie Mo**
Address _____ Date signed _____

609

RECEIVED

District Health Officer No. 2

District File Number 341-297

Date Filed 3/5/46

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.

Registration District No. 836

Primary Registration District No. 6098A

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

1. PLACE OF DEATH:

(a) County Stoddard
 (b) City or town Liberty, Mo.
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: _____
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____ (Specify whether _____)
 In this community _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME Chloe Kathleen Ray

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

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced S

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	Months	Days	If less than one day
		<u>5</u>	<u>11</u>	_____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

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) _____ (b) Date thereof (Month) (Day) (Year) _____
 (Burial, cremation, or removal) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) _____ (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

(c) City or town _____ (If outside city or town limits, write "RURAL")
 (d) Street No. _____ (If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 7
 year 1941 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive _____ and that death occurred on the date and hour stated above.
 Immediate cause of death Pneumonia Duration _____

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

Major findings: Of operations _____

Of autopsy _____

Due to _____

Due to _____

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) _____ (e) Means of injury _____

23. Signature Bernie M (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTAL

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, fact should be so stated above.