No. 2
-11-10-39
5-17-39
I X21492

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25259

Registration District No. 400 Primary Registration District No. 55 53 B Registrar's No. 131

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

1. PLACE OF DEATH:

(a) County Jackson

(b) City or town Prairie Township (If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Jackson County Home for the aged & infirm (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 15 months (Specify whether years, months or days)

In this community 45 Years

2. USUAL RESIDENCE OF DECEASED: 048

(a) State Mo (b) County Jackson

(c) City or town Kansas city (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.? 0 years.

3. (a) PRINT FULL NAME Frank Ray

3. (b) If veteran, name war Mo

3. (c) Social Security No. Mo

4. Sex M 0

5. Color or race W

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

6. (b) Name of husband or wife unknown

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

7. Birth date of deceased Jan (Month) 17 (Day) 1879 (Year)

8. AGE: Years 62 Months 6 Days 28 If less than one day hr. min.

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

10. Usual occupation Bill Poster

11. Industry or business

FATHER
12. Name James Ray
13. Birthplace unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Rebecca Weaver
15. Birthplace unknown (City, town, or county) (State or foreign country)

16. (a) Informant Records Jackson County Home

(b) Address Little Blue Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 18-41 (Month) (Day) (Year)

(c) Place: burial or cremation Forrest Hill Ft C Mo

18. (a) Signature of funeral director N B Langsford

(b) Address Lee Summit Mo

19. (a) 8-16-41 (Date received local registrar) (b) Sara G. Barnes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15 year 1941 hour 7 minute 05 a M.

21. I hereby certify that I attended the deceased from Aug 1, 1941, to Aug 15, 1941, that I last saw him alive on 8/14, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death chronic myocarditis

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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

23. Signature J W Greene (M. D. ~~or other~~ D)

Address Independence Date signed 8/15-41

132 (Licensed Embalmer's Statement on Reverse Side)

AUG 19 1941

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. 1383

P. O. Address Lees Summit

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

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

S. No. 2B
I—8-21-41
P I X29288

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25259

Registration District No. 400 Primary Registration District No. 5553B Registrar's No. 131

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Little Blue Prairie Twp
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Jackson Co. Home for the Aged Infirm
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 15 mo (Specify whether
In this community ~~15 years~~ 15 Mo.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Jackson
(c) City or town Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No. 7 Francis
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Frank Ray

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 | Months | Days | If less than one day 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) (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) 9-16-41 (Date received local registrar) (b) Sara E. Bennes (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 15 year 1941 hour minute M.

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

	Duration
Immediate cause of death	
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)
(b) 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

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

SUPPLEMENTARY

S-25259