

FILED OCT 10 1941

Registration District No. **198**

Primary Registration District No. **3011**

Registrar's No. **135**

1. PLACE OF DEATH:

(a) County Clay  
 (b) City or town Excelsior Springs  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
South Liberty St.  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether)  
 In this community 6 years years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay **24**  
 (c) City or town Excelsior Springs  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. South Liberty St.  
 (If rural, give location) **1**  
 (e) Citizen of foreign country? No. (Yes or No) **0**  
 If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel Wilma Ray

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

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife William "Jake" Ray 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased May 22 1901  
 (Month) (Day) (Year)

8. AGE: Years 40 Months 3 Days 26 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation At home

MOTHER FATHER { 11. Industry or business \_\_\_\_\_

12. Name Wilber Martin

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

14. Maiden name Viola Maude Meyers

15. Birthplace Valley Falls Kansas  
 (City, town, or county) (State or foreign country)

16. (a) Informant William R. Ray

(b) Address Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof Sept - 21 - 41  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Crown Hill, Ex. Spgs. Mo.

18. (a) Signature of funeral director Claude Prichard

(b) Address Excelsior Springs, Missouri

19. (a) Sept 20 - 1941 (b) Miss R. M. Cracker  
 (Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 18  
 year 1941 hour 11:55 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Feb 27 1939 to Sept 16 1941  
 that I last saw her alive on Sept 16 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage Duration \_\_\_\_\_

Due to \_\_\_\_\_

Due to Hypertension - following self-poisoning about 3 years

Other conditions albuminuria  
 (include pregnancy within 3 months of death)

Major findings: Of operations 0

Of autopsy 0 **1480**  
 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 0

(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 R. M. Cracker (M.D. or other) 9/16/41

Address Excelsior Springs, Mo. Date signed \_\_\_\_\_

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 10-9-41

**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..... *Robert Ray* .....  
Licensed Embalmer No. *4182* .....  
P. O. Address. *Excelsior Springs,* .....

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)**  
**If this body is not embalmed, fact should be so stated above.**

STANDARD CERTIFICATE OF DEATH

State File No. **31367**

Registration District No. **198**

Primary Registration District No. **3011**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

- (a) County Clay  
 (b) City or town Excelsior, 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 years, months or days)  
 In this community 6 yrs

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 \_\_\_\_\_

3. (a) PRINT FULL NAME Ethel W. 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 m  
 6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
 7. Birth date of deceased May 22, 1900  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day in min.
	<u>40</u>	<u>3</u>	<u>6</u>	

9. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
 10. Usual occupation \_\_\_\_\_  
 11. Industry of 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) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation \_\_\_\_\_  
 18. (a) Signature of funeral director \_\_\_\_\_  
 (b) Address \_\_\_\_\_

19. (a) 4/18/41 (b) Miss Ruth McCreash  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day \_\_\_\_\_  
 year 1941 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw him/her alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Duration \_\_\_\_\_

- Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN

- Major findings:  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_  
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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

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

2B  
-41  
9288

S-31367 1941