

FILED JUN 13 1942

Registration District No. 547

Primary Registration District No. 3029

Registrar's No. 135

1. PLACE OF DEATH:

(a) County: Marion  
(b) City or town: Hannibal, Mo.  
(c) Name of hospital or institution: St. Elizabeth Hospital  
(d) Length of stay: In hospital or institution: 2 weeks  
In this community: Entire life

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Marion  
(c) City or town: Rural  
(d) Street No.: Palmyra Road, Hannibal, Mo.  
(e) Citizen of foreign country? No

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: May day: 8  
year: 1942 hour: 4 minute: 5 A.M.  
21. I hereby certify that I attended the deceased from 4/18/42  
to 5/8/42, 1942  
that I last saw him alive on May 8, 1942  
and that death occurred on the date and hour stated above.

3. (a) PRINT FULL NAME: James Thaddius Ray

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

4. Sex: male 5. Color or race: white 6. (a) Single, widowed, married, divorced: married

6. (b) Name of husband or wife: Susan Frances Ray 6. (c) Age of husband or wife if alive: 75 years

7. Birth date of deceased: December 27, 1853 (Month) (Day) (Year)

8. AGE: Years: 88 Months: 4 Days: 11 If less than one day: hr. min.

9. Birthplace: Sydney, Bollinger County, Missouri (City, town, or county) (State or foreign country)

10. Usual occupation: Retired Farmer

11. Industry or business:

12. Name: John Murry Ray (City, town, or county) (State or foreign country)

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

14. Maiden name: Elizabeth Summers (City, town, or county) (State or foreign country)

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

16. (a) Informant: Mrs. Kate Ray Ruhn (b) Address: R.R. #2, Hannibal, Mo.

17. (a) Burial, cremation, or removal: Burial (b) Date thereof: May 9, 1942 (Month) (Day) (Year)

(c) Place: burial or cremation: Mt. Olive cemetery

18. (a) Signature of funeral director: Roy P. Schwartz (b) Address: 1000 Edw. Hannibal, Mo.

19. (a) Date received local registrar: 5-20-42 (b) Registrar's signature: R. H. Connor

Immediate cause of death: Pneumonia  
Chronic myocarditis with  
Auricular fibrillation  
Duration: 2 1/2 weeks  
3 years

Other conditions: Scurvy, Arteriosclerosis  
(Include pregnancy within 4 months of death)

Major findings: Of operations: None  
Of autopsy: None

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?

23. Signature: Daniel B. Laska (M.D. or other)  
Address: Hannibal, Mo. Date signed: 5/19/42

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

MOTHER FATHER

LE 111

**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 Roy P. Schwartz

Licensed Embalmer No. 1785

P. O. Address 1070 Redway, Hamilton

**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, fact should be so stated above.**

STANDARD CERTIFICATE OF DEATH

Registration District No. 5417

Primary Registration District No. 3029

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

1. PLACE OF DEATH

(a) County Marion

(b) City or town Hannibal  
(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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME James J. 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 M

6. (b) Name of husband or wife \_\_\_\_\_

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

7. Birth date of deceased: Dec 27 1888  
(Month) (Day) (Year)

8. AGE: Years 88 Months 4 Days 10  
(If less than one day \_\_\_\_\_ 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) \_\_\_\_\_ (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) \_\_\_\_\_ (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 May Day \_\_\_\_\_ Year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 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 \_\_\_\_\_

Due to Pneumonia

Due to Bronchopneumonia

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? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

MOTHER FATHER

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

