No. 2
-5-42
-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 25595

FILED AUG 3 1943

Registration District No. 237 Primary Registration District No. 4353 Registrar's No. 21

1. PLACE OF DEATH:
(a) County: Gideon
(b) City or town: Gideon Twp. City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Home
(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: 20 yr.

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: New Madrid
(c) City or town: Gideon City
(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: 0

3. (a) PRINT FULL NAME: Ingram, Ray
3. (b) If veteran, name war: —
3. (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: Nettie Ray
6. (c) Age of husband or wife if alive: about 70 years
7. Birth date of deceased: Dec (Month) 9 (Day) 1870 (Year)

8. AGE: Years 73 | Months 7 | Days — | If less than one day ..... hr. ..... min.

9. Birthplace: Tennessee (City, town, or county) / (State or foreign country)
10. Usual occupation: Farming
11. Industry or business: "
FATHER
12. Name: Sam Ray
13. Birthplace: Tenn. (City, town, or county) / (State or foreign country)
MOTHER
14. Maiden name: Cornelia Wilkerson
15. Birthplace: Tenn (City, town, or county) / (State or foreign country)
16. (a) Informant: Minnie Gordon
(b) Address: Gideon
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 7-11-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Mt Gilead
18. (a) Signature of funeral director: Landers Funeral Home
(b) Address: Campbell Mo
19. (a) July 10-43 (Date received local registrar) (b) Zenda Macom (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July 9 day ..... year 1943 hour — minute 30 A.M.
21. I hereby certify that I attended the deceased from June 1 1943 to July 8 1943 that I last saw him alive on alive July 8 1943 and that death occurred on the date and hour stated above.
Immediate cause of death: Cardiac Hypertension with failing Compensation
Duration: 17 yr.
Due to: .....
Due to: .....
Other conditions (Include pregnancy within 3 months of death): 920
Major findings:
Of operations: .....
Of autopsy: no

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): 0
(b) Date of occurrence: 0
(c) Where did injury occur? none (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? 0
While at work? ..... (Specify type of place) (e) Means of injury: .....
23. Signature: [illegible] (M. D. or other)
Address: Gideon Mo Date signed July 9 1943

(Licensed Embalmer's Statement on Reverse Side)

AUG 3 1967

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 Christine Landers, Registered Apprentice No. working under my personal supervision.

Signed Christine Landers

Licensed Embalmer No. 4227

P. O. Address Campbell Mo

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.

No. 2B
—5-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. .....

Registration District No. 237 Primary Registration District No. (4353) Registrar's No. 21

1. PLACE OF DEATH:

(a) County New Madrid

(b) City or town Gideon
(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 20 yrs.

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County New Madrid

(c) City or town Gideon City
(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 Ingram 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 (Month) 9 (Day) 1870 (Year)

8. AGE: Years 73 Months 7 Days ..... Unless than one day ..... hr. ..... min.

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

10. Usual occupation .....

11. Industry or business .....

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

MOTHER
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) ..... (Date received local registrar) (b) Linda Macon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July Day 9 year 1943 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.

Immediate cause of death ..... Duration

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

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

SUPPLEMENTARY

S-25595