

3. No. 2
1-5-42
5-17-39
X32873

FILED SEP 8 1944

Registration District No. 38

Primary Registration District No. 4088

Registrar's No. 15-

1. PLACE OF DEATH:

(a) County Carter
(b) City or town Ellsinore
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 years, months or days (Specify whether)
In this community 7 years, months or days

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME THOMAS GORDON RAY
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month Aug day 12 year 1944 hour 8 minute 30 P.M.

4. Sex M 5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Maudie 6. (c) Age of husband or wife if alive 76 years
7. Birth date of deceased Aug 6 1849
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from June 11 1944 to Aug 12 1944 that I last saw him alive on Aug 12 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of throat Duration 3 mo.

8. AGE: Years 95 Months _____ Days 6 If less than one day _____ hr. _____ min.

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____
Major findings: Of operations _____
Of autopsy _____

9. Birthplace Ken 1 (City, town, or county) (State or foreign country)
10. Usual occupation retired

11. Industry or business _____
12. Name unknown
13. Birthplace " 9 (City, town, or county) (State or foreign country)
14. Maiden name unknown
15. Birthplace " 9 (City, town, or county) (State or foreign country)

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 _____

16. (a) Informant Mrs Maudie Ray
(b) Address Ellsinore Mo
17. (a) burial (b) Date thereof 9-14-44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Dexter Mo
18. (a) Signature of funeral director Phil A Leichel
(b) Address Van Buren Mo
19. (a) Aug 13 1944 (b) mo A J Smith
(Date received local registrar) (Registrar's signature)

23. Signature Frank Rusinski (M. D. or other) D.O.
Address Van Buren Mo Date signed 8-14-44

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

MOTHER FATHER

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 9-13-44

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

Signed Shelby C. Funchel

Licensed Embalmer No. 2936

P. O. Address Van Buren 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.