

FILED MAR 19 1951

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **11392**

BIRTH NO. _____ REG. DIST. NO. **374** PRIMARY REG. DIST. NO. **4547** Registrar's No. **9**

1. PLACE OF DEATH a. COUNTY Worth County		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY Worth	
b. CITY (If outside corporate limits, write RURAL and give town) Grant city		c. CITY (If outside corporate limits, write RURAL and give township) Grant City	
c. LENGTH OF STAY (In this place) 5 yrs		1130	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print)	a. (First) James	b. (Middle) Garfield	c. (Last) Ray	4. DATE OF DEATH (Month) (Day) (Year) 3 9 1951
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8 23 1881	9. AGE (In years last birthday) 69	IF UNDER 1 YEAR Months 6	IF UNDER 1 YEAR Days 16	IF UNDER 4 HRS. Hour 16 Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	10b. KIND OF BUSINESS OR INDUSTRY Farming-for self	11. BIRTHPLACE (State or foreign country) Grant City, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME Bee Ray	13b. MOTHER'S MAIDEN NAME Elizabeth Rowen	14. NAME OF HUSBAND OR WIFE Laura Ray
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Mrs. Tessie Lynch Sheridan, Mo.	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH 18 hours
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from **3-8**, 19**51**, to **3-9**, 19**51**, that I last saw the deceased alive on **3-9**, 19**51**, and that death occurred at **11 A** m., from the causes and on the date stated above.

23a. SIGNATURE Frank B. Madison (Degree or title) MD	23b. ADDRESS Grant City, Mo	23c. DATE SIGNED 3/10/51
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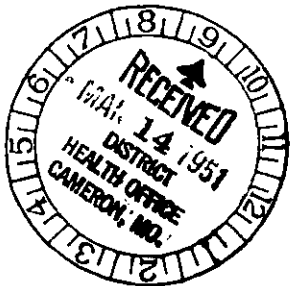
24a. BURIAL CREMATION REMOVAL (Specify) Burial	24b. DATE 3 11 1951	24c. NAME OF CEMETERY OR CREMATORY Isadora Cemetery	24d. LOCATION (City, town, or county) (State) Grant City, Mo.
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DATE REC'D BY LOCAL REG. March 12 1951	REGISTRAR'S SIGNATURE Teta E. Dawson 345	25. FUNERAL DIRECTOR'S SIGNATURE Arch C. Temple	ADDRESS Grant City, Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

1130



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.....

..... Student Embalmer No.

working under my personal supervision.

Student
Student Embalmer

Signed Arch C. Dangle

Licensed Embalmer No. 3252

P. O. Address Grant City, 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.