

Health,
& Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-039591

STATE FILE NUMBER

FILED DEC 15 1958

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1166

300
1-57

1. PLACE OF DEATH a. COUNTY GREENE		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY HOWELL	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN SPRINGFIELD		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN MOODY 0460 0
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. JOHN'S HOSP		Length of stay in lb 14 DAYS	d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last CHRISTOPHER COLUMBUS RAY			4. DATE OF DEATH Month Day Year DEC 3, 1958		
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5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 23, 1878	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant and Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country) Sharp County, Mo	12. CITIZEN OF WHAT COUNTRY? USA
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13a. FATHER'S NAME A. Ray		13b. MOTHER'S MAIDEN NAME Betty Battles	14. NAME OF HUSBAND OR WIFE Betty M. Ray (Dec)		
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 487-10-5531 A	17. INFORMANT Amos Ray, Moody Mo	Address		
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH 5 min.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		DUE TO (b) Patient was operated for benign prostatic hyperplasia and transitional cell carcinoma of bladder		
		DUE TO (c) of bladder		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)			
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20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.				
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20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from 11-15-58 to 12-3-58 and last saw her alive on 12-3-58 Death occurred at 11:30 AM m on the date stated above; and to the best of my knowledge, from the causes stated.				
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22a. SIGNATURE (Degree or title) <i>Amos Ray</i>	22b. ADDRESS 609 Cherry, Springfield, Mo	22c. DATE SIGNED 12-11-58
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23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 12-6-58	23c. NAME OF CEMETERY OR CREMATORY Free Union Cem	23d. LOCATION (City, town, or county) (State) Howell County, Mo
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24. FUNERAL DIRECTOR Carter Funeral Home, West Plains Mo	ADDRESS	25. DATE RECD. BY LOCAL REG. 12-12-58	26. REGISTRAR'S SIGNATURE <i>Effie S. Melton</i>
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(Licensed Embalmer's Statement on Reverse Side)

Secretary, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

JUL 8 1968

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
Signature of Student Embalmer

Signed *R. L. McCann*

Licensed Embalmer No. *2727*

P. O. Address *Springfield, 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.