

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-037925

FILED VS NOV 10 1960

STATE FILE NUMBER

Registration District No. 107 Primary Registration District No. 3019 Registrar's No. 211

1. PLACE OF DEATH a. COUNTY <u>Dunklin</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>Dunklin</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Kennett</u>		Length of stay in 1b <u>4 days</u>		c. CITY OR TOWN <u>Kennett</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR <u>Dunklin County Memorial</u> INSTITUTION <u>Hospital</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>808 N. Main St.</u>	
3. NAME OF DECEASED (Type or print) First <u>EFFIE</u> Middle _____ Last <u>RAY</u>				4. DATE OF DEATH Month <u>October</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 14, 1900</u>	
				9. AGE (last birthday) <u>60</u>		IF UNDER 1 YEAR Months _____ Days _____	
						IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>Dunklin County, Mo.</u>	
						12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>Josh W. Wright</u>				13b. MOTHER'S MAIDEN NAME <u>Victoria Cooper</u>		14. NAME OF HUSBAND OR WIFE <u>Willie R. Ray</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Willie R. Ray</u> Address <u>Kennett, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Hours -</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)							
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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.)			
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.		Month, Day, Year					
20d. INJURY OCCURRED WHILE AT WORK <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	
21. I attended the deceased from <u>Oct. 15-1960</u> to <u>Oct. 18-</u> and last saw her <u>alive</u> on <u>Oct. 18, 1960</u> Death occurred at <u>9:45 p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Joe A. Zimmerman, M.D.</u>				22b. ADDRESS <u>Kennett, Missouri</u>		22c. DATE SIGNED <u>11-3-60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Oct. 21, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>North Canaan Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Campbell, Missouri</u>	
24. FUNERAL DIRECTOR <u>Landess Funeral Home, Campbell, Mo</u>				ADDRESS		25. DATE RECD. BY LOCAL REG. <u>11-4-1960</u>	
26. REGISTRAR'S SIGNATURE <u>Carl Husband</u>							

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 1 1961

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by \_\_\_\_\_  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Christine M. Land

Licensed Embalmer No. 422

P. O. Address Campbell

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.