

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-004657

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 176

STATE FILE NUMBER

AMENDED

FILED VS. FEB 20 1961

1. PLACE OF DEATH a. COUNTY <u>Buchanan</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Buchanan</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Joseph</u>	Length of stay in 1b <u>67 years</u>	c. CITY OR TOWN <u>St. Joseph</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Wilson Nursing Home 677 North 17th Street</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6309 South 3rd Street</u>

3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>H.</u> Last <u>Ray</u>			4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>1961</u>			
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5. SEX <u>Male</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>July 24, 1876</u>	9. AGE (last birthday) <u>84</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Plasterer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	11. BIRTHPLACE (City and state or country) <u>Holt County, Mo.</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>
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13a. FATHER'S NAME <u>William B. Ray</u>	13b. MOTHER'S MAIDEN NAME <u>Ellen Viola Dyer</u>	14. NAME OF HUSBAND OR WIFE <u>Mary E. Ray</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, <u>unknown</u>) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT Address <u>Mary E. Ray 6309 So. 3rd St.</u>
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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) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unk.</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
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input 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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____
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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
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21. I attended the deceased from 8/11/59 to 2/11/61 and last saw her alive on 2/13/61
Death occurred at 7:00 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>S.T. Meloney M.D.</u>	22b. ADDRESS <u>10th & Olive, Patee Hall St. Joseph, Missouri</u>	22c. DATE SIGNED <u>2/15/61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Feb. 16, 1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Public Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Joseph, Mo.</u>
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24. FUNERAL DIRECTOR ADDRESS <u>Clark Funeral Home St. Joseph, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>Feb. 15, 1961</u>	26. REGISTRAR'S SIGNATURE <u>Mrs. Clark Stoddell</u>
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DATE AMENDED: _____
 ITEM NO. SHOULD READ _____
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS _____
 INSTEAD OF _____
 DOCUMENT _____
 BY AFFIDAVIT OF _____
 S.T. Meloney Medical Certification

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 Evan A Clark

Licensed Embalmer No. 4238

P. O. Address St. Joseph

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.