

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-011872

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 1837 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED APR 4 1963

VS 300
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>JACKSON</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>JACKSON</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u> | | Length of stay in lb <u>18 years</u> | c. CITY OR TOWN <u>KANSAS CITY</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>326 SPRUCE AVENUE</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) <u>326 SPRUCE AVE.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED First Middle Last <u>ROBERT L RAY</u> | | | 4. DATE OF DEATH Month Day Year <u>March 20 1963</u> |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc</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>Oct 24 1901</u> |
| 9. AGE (last birthday) <u>61</u> | | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HR Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Attendant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Managers Service Station</u> | 11. BIRTHPLACE (City and state or country) <u>Fulton Co. Arkansas U.S.A.</u> |
| 12. CITIZEN OF WHAT COUNTRY | | 13a. FATHER'S NAME <u>Miles M RAY</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Ruby Mae Jennings</u> | | 14. NAME OF HUSBAND OR WIFE <u>TRESSIE L 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>2 TRESSIE L RAY, 326 Spruce K.C. Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Severe Rheumatoid arthritis + emaciation many years</u> | | | |
| 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>12/28/60</u> to <u>3/20/63</u> and last saw her him alive on <u>3/19/63</u> Death occurred at <u>11:00 A.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated. | | | |
| 22a. SIGNATURE (Degree or title) <u>Wilson H. Miller M.D.</u> | | 22b. ADDRESS <u>3626 Independence Ave Kansas City 24, Mo.</u> | 22c. DATE SIGNED <u>3/20/63</u> |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE <u>March 23 1963</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Maria Cemetery</u> | 23d. LOCATION (City, town, or county) (State) <u>Kansas City, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>O.W. Newcome Sons</u> | ADDRESS <u>1331 Bush Creek Kansas City, Missouri</u> | 25. DATE RECD. BY LOCAL REG. <u>3-22-63</u> | 26. REGISTRAR'S SIGNATURE <u>Ruth Long</u> |

USE BLACK INK OR TYPEWRITER RIBBON

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 Dean W. Huff

Licensed Embalmer No. 4914

P. O. Address Gruber, 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.

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