

JUL 8 - 1937

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County
Township
City

Registration District No. **791**
Primary Registration District No. **1003**

File No. **22510**
Registered No. **6262**
St. Ward

2. FULL NAME

Ray Glaven

(a) Residence, No. *412 Pine St* St. *25* Ward.
(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) *Single*

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *✓*

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *Feb 1909*

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
3 8 *—* *—*

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Entertainer*
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *unknown*
10. Date deceased last worked at this occupation (month and year) *✓* 11. Total time (years) spent in this occupation *✓*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Kentucky*

13. NAME *Unknown*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

15. MAIDEN NAME *Unknown*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Unknown*

17. INFORMANT (ADDRESS) *City Hospital #1*

18. BURIAL, CREMATION, OR REMOVAL PLACE *Washington* DATE *6-12-37*

19. UNDERTAKER (ADDRESS) *Medical Board*

20. FULL NAME *J. A. Bredeck* Registrar.

No Physician in attendance MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *5/30/1937*

22. I HEREBY CERTIFY, That I attended deceased from, 19....., to, 19.....

I last saw h..... alive on, 19..... Death is said to have occurred on the date stated above, at *1:30* m.

The principal cause of death and related causes of importance were as follows:

Toxemia from Generalized Peritonitis (Typhoid fever)

Other contributory causes of importance:

Broncho Pneumonia

Name of operation Date of

What test confirmed diagnosis? *✓* Was there an autopsy? *Yes*

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Date of injury, 19.....

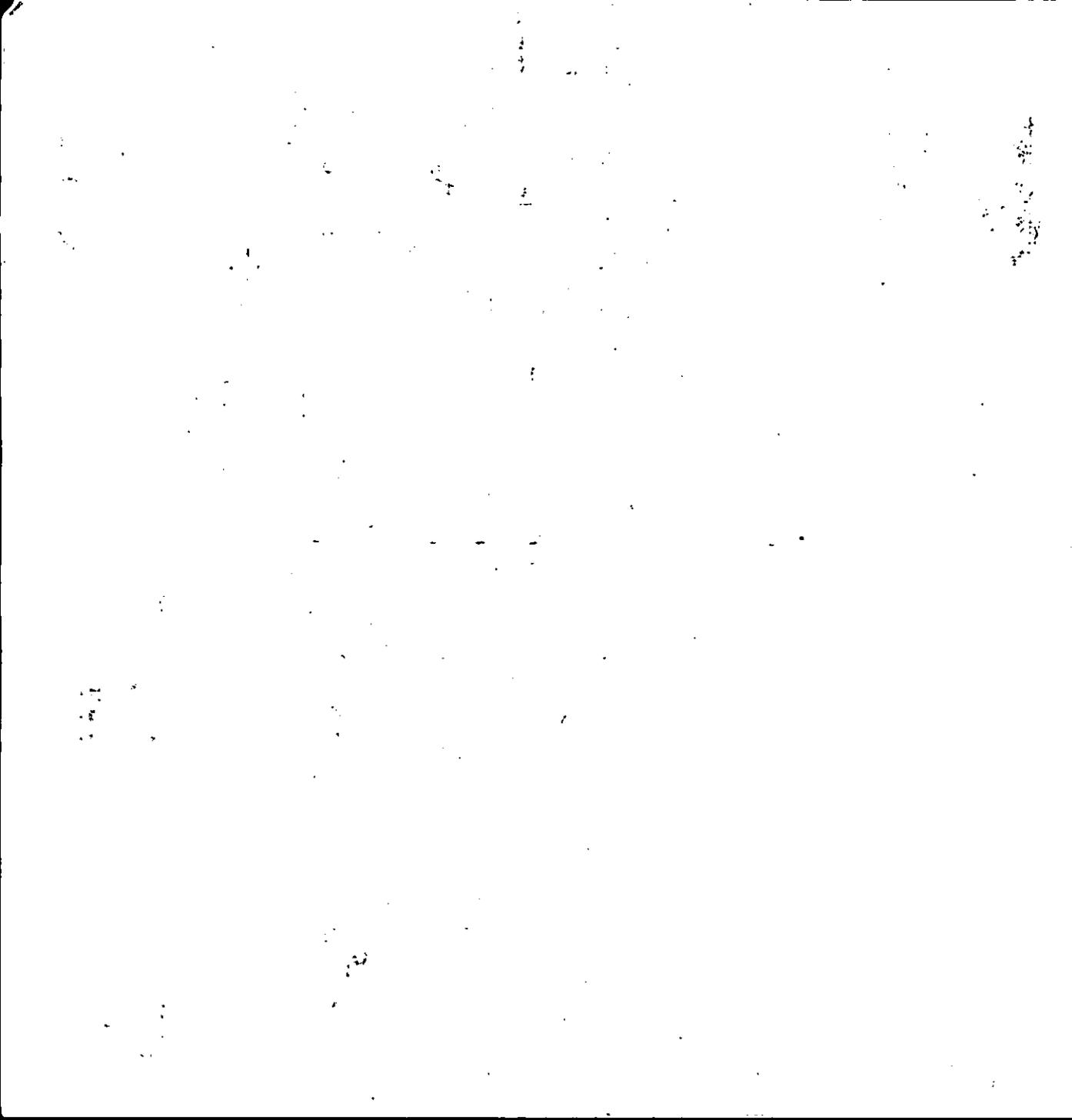
Where did injury occur? (Specify city or town, county, and State) Specify whether injury occurred in industry, in home, or in public place.

Manner of injury *See above*
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? *No*

If so, specify *Joseph M. Quinn* (Signed) *Deputy Coroner* (Address)

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MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

1. PLACE OF DEATH

County St Louis

Registration District No. 1791

File No. 223-10

Township St Louis

Primary Registration District No. 1003

Registered No. 6262

City St Louis (No. St. Ward)

2. FULL NAME

Ray GLOREM

(a) Residence, No. St. Ward.

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) S

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS 38 MONTHS DAYS If LESS than 1 day, or

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

15. MAIDEN NAME

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE DATE 19

19. UNDERTAKER (ADDRESS)

20. FILED 8-10 1937 J F Bredeck Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 19.....

22. I HEREBY CERTIFY, That I attended deceased from

....., 19....., to 19.....

I last saw alive on 19..... Death is said

to have occurred on the date stated above, at m.

The principal cause of death and related causes of importance were as follows:

Date of onset

Other contributory causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? Date of injury 19.....

Where did injury occur?

(Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) Joseph M. Quinn, M. D.

(Address) 1025 E. Car

