

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REC'D OCT 12 1938

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

30325  
Do not use this space.

1. PLACE OF DEATH

(a) County .....  
(b) Township .....  
(c) City St. Louis (d) Street No. Homer Phillips Hospital St.  
(If death occurred in Hospital or Institution, write its name instead of street and number)  
(e) Length of residence in city or town where death occurred 42 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

791

1008

Registered No. 7762

2. PRINT FULL NAME

George Raymond  
(a) Residence, No. 2702 Dayton St. 21  
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

553

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct. 1, 1867

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
70 10 28

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. nil  
9. Industry or business in which work was done, as 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) Missouri

13. NAME Carol Raymond

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

15. MAIDEN NAME Nancy Weaver

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

17. INFORMANT (ADDRESS) Evelyn Hilliard 2601 N Whittier

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood DATE Sep 1st 1938

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Jas. H. Randle & Son 3133 Bell Ave

20. FILED SEP - 1 1938 J. B. Beecher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Aug. 29 19 38

22. I HEREBY CERTIFY, That I attended deceased from June 5, 19 38, to Aug. 29, 19 38

I last saw him alive on Aug. 29, 19 38. Death is said to have occurred on the date stated above, at 4:13a.m.

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

Cancer of mouth floor of mouth

Date of onset 6/5/38

Other contributory causes of importance: 45C

Name of operation ..... Date of .....  
What test confirmed diagnosis? clinical Was there an autopsy? NO

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) James H. Randle, M. D.  
(Address) 2601 N Whittier

**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 \_\_\_\_\_

Registered Apprentice, No. \_\_\_\_\_, working under my personal supervision.

Signed \_\_\_\_\_

Licensed Embalmer No. 2698

P. O. Address 2769 Chouteau

**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 this body is not embalmed, above space should be left blank.**