

REC'D FEB 10 1939

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

791
1003

521

Do not use this space.

521

1. PLACE OF DEATH

(a) County Registration District No.
(b) Township Primary Registration District No. Registered No.
(c) City St. Louis (d) Street No. City Hospital No. 1 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 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

D. 13262

560

William Raymer

2. PRINT FULL NAME

(a) Residence, No. 1427 a St. Louis 26 (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Jan 2, 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
54 13

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. barber
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

FATHER 13. NAME Isaac Raymer

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

MOTHER 15. MAIDEN NAME Sarah Unknown

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

17. INFORMANT Hosp. Infom. Kent
(ADDRESS) City Hospital No. 1

18. BURIAL, CREMATION, OR REMOVAL PLACE Ellsinore Mo DATE Jan 18 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Beiderwieden Funl Home Inc
1936 St Louis Ave

20. FILED JAN 17 1939
J. B. Beiderwieden
Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1/15/39, 19.....

22. I HEREBY CERTIFY That I attended deceased from 12/9/38 to 1/15/39, 19.....

I last saw him 1/15/39, 19..... Death is said to have occurred on the date stated above, at 11.40 a.m.

The principal cause of death and related causes of importance were as follows:
Chronic Cholecystitis, Stones
Peritonitis, acute

Date of onset

Other contributory causes of importance: 126

Name of operation Cholecystectomy Date of 1-4-39
What test confirmed diagnosis? 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) Albert H. Krause M. D.
(Address) City Hospital No. 1

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.....

[Handwritten Signature]
Licensed Embalmer No. 3737

P. O. Address 1936 St. Louis

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.