

REC'D AUG 11 1939

Registration District No.

791

Primary Registration District No.

Registrar's No.

5919

1. PLACE OF DEATH:

1003

(a) County _____
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
St. Anthony's Hospital 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
(Specify whether _____)
In this community _____
years, months or days

3. (a) PRINT FULL NAME WALTER RAY (OOD)

3. (b) If veteran, name war no 3. (c) Social Security No. 497-03-7325

4. Sex MALE 5. Color or race COL 6. (a) Single, widowed, married, divorced WIDOWED

6. (b) Name of husband or wife BESSIE RAY 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased _____
(Month) (Day) (Year)

8. AGE: Years 49 Months 5 Days 5 If less than one day _____ hr. _____ min.

9. Birthplace Mo.
(City, town, or county) (State or foreign country)

10. Usual occupation HIGH CARRIER for a Contractor

11. Industry or business _____

12. Name JERRY RAY

13. Birthplace TENN
(City, town, or county) (State or foreign country)

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Jerry Ray

(b) Address 506 E. Emma

17. (a) Burial (b) Date thereof July 6 39
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemetery

18. (a) Signature of funeral director Reynold Lane

(b) Address 3103 Washington Blvd

19. (a) III 5-1939 (b) J.P. Brink
(Date of local registration) (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State 1 (b) County _____
(c) City or town ST. LOUIS, MO. 21
(If outside city or town limits, write "RURAL")
(d) Street No. 3108 WASHINGTON
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 30th
year 1939 hour 5:25 minute P. M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage of Brain, Traumatic, suffered in fall from a scaffold while working at 3000 So. Second Street about 3:45 P.M., June 30th, 1939.

Due to CAUSE AND MANNER OF SAME COULD NOT BE DETERMINED: OPEN VERDICT

Other conditions OPEN VERDICT
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____
Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence June 30th, 1939

(c) Where did injury occur? St. Louis, Mo.
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In Industrial place

While at work Yes (Specify type of place) (e) Means of injury Fall

23. Signature Jerry N. Brink (M.D. or other)
Address Deputy Coroner Date signed 7/2

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.

1939
70
1869

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 _____

William C. McDowell, Registered Apprentice No. _____
working under my personal supervision.

Signed _____

Licensed Embalmer No. 2114

P. O. Address _____

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.