

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

24531
Do not use this space.

REC'D AUG 7 1939

1. PLACE OF DEATH
 (a) County Jackson Registration District No. 399
 (b) Township Raw Primary Registration District No. 1002 Registered No. 2744
 (c) City St. Louis (d) Street No. 1100 Sun Hosp 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.

2. PRINT FULL NAME John Ray
 (a) Residence, No. Oakley Hotel St. (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 M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Not known
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. min.
88 Not known
 OCCUPATION 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. Clerk
 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) Scotland
 FATHER 13. NAME Unknown
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 MOTHER 15. MAIDEN NAME Unknown
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown
 17. INFORMANT (ADDRESS) Record Clerk
1100 Sun Hosp
 18. BURIAL, CREMATION, OR REMOVAL PLACE St. Louis DATE July 8, 1939
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) John J. O'Neil
35 N. M. Grove
 20. FILE NO. _____ Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 7-5-39, 1939
 22. I HEREBY CERTIFY, That I attended deceased from 7-3-39, 1939 to 7-7-39, 1939.
 I last saw him live on 7-7-39, 1939. Death is said to have occurred on the date stated above, at 6:59 p.m.
 The principal cause of death and related causes of importance were as follows:
Chronic disease
myocardial Fibrosis
Acute and Chronic 930
 Other contributory causes of importance:
Pulmonary Congestion
Central Edema
 Name of operation _____ Date of _____
 What test confirmed diagnosis Autopsy 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 _____, 1939
 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) P. F. De Maria M. D.
Sept. 11 C. Sun Hosp (Address)

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

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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.

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.