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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 6 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 29844

Registration District No. 818 Primary Registration District No. 1066 Registrar's No. 8341

1. PLACE OF DEATH:

(a) County
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 18 days (Specify whether years, months or days)
In this community 38 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County
(c) City or town St. Louis, (If outside city or town limits, write "RURAL")
(d) Street No. 4515 Enright Avenue (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. [redacted]NT FULL NAME Bertha Ray

3. (b) If veteran, name war None
3. (c) Social Security No. None

4. Sex F
5. Color or race Col
6. (a) Single, widowed, married, divorced Widow
6. (b) Name of husband or wife Major Ray
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jan (Month) 27 (Day) 1880 (Year)

8. AGE: Years 64 Months 8 Days 0 If less than one day hr. min.

9. Birthplace New Gascony (City, town, or county) Ark (State or foreign country)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Dave Langford
13. Birthplace Unknown (City, town, or county) Miss (State or foreign country)

MOTHER
14. Maiden name Maviah Kane
15. Birthplace Unknown (City, town, or county) Ark (State or foreign country)

16. (a) Informant Esther Rose
(b) Address 4515 Enright Ave
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 2 -44 (Month) (Day) (Year)
(c) Place: burial or cremation Greenwood Cem
18. (a) Signature of funeral director Manuel Und. Co
(b) Address 359 Finney Ave
19. (a) SEP 30 1944 (Date received by local registrar) (b) J. F. Bredeck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 27, year 1944 hour 8 minute 00 A. M.
21. I hereby certify that I attended the deceased from September 9, 1944 to September 27, 1944; that I last saw her alive on September 27, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Gastro-intestinal malignancy	Unk.
Due to	
Due to	
Other conditions (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
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D.)
Address Date signed

844

(Licensed Embalmer's Statement on Reverse Side)

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 William C. McDowell

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, fact should be so stated above.