

No. 5-43  
5-17-39  
X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **25636**  
Registrar's No. **6142**

Registration District No. **3182 1948** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town St. Louis  
(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)  
(d) Length of stay: In hospital or institution 1 day  
(Specify whether  
In this community.....  
years, months or days)

3. (a) PRINT FULL NAME FRED RAY

3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Male 2 5. Color or race Col 6. (a) Single, widowed, married, divorced Single

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

7. Birth date of deceased June 6 1892  
(Month) (Day) (Year)

8. AGE: Years Months Days 3 If less than one day  
54 1 2 .....hr. ....min.

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

10. Usual occupation Houseman

11. Industry or business.....

12. Name Unknown

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

14. Maiden name..... (City, town, or county) (State or foreign country)

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

16. (a) Informant S. Wray Pringle - 4037 W. Belle

(b) Address..... (c) Place: burial or cremation Greenwood Cem.

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

18. (a) Signature of funeral director Jordan M. Chambers

(b) Address 31002 Hubler Ave.

19. (a) JUL 12 1948 (Date received local registrar) J. F. Bredek (Registrar's signature)

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. 2015 Market  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 9  
year 1946 hour 8 minute 15 P.M.

21. I hereby certify that I attended the deceased from 7-8 to 7-9, 1946  
that I last saw him alive on 7-9, 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death.....  
Septicemia

Due to.....

Due to.....

Other conditions Tertiary Lues  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations.....

Of autopsy No

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

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

(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?

1. While at work..... (Specify type of place) (2) Means of injury.....

23. Signature J. F. Bredek (M. D. or other) 7/11/46  
Address 2601 N. Whittier Date signed

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

**. 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.....

*John H. Petrus*

Licensed Embalmer No. *24184*

P. O. Address..... *St. Louis, Mo.*

**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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No.

*Aug*  
*6142*

Registration District No. *818*

Primary Registration District No. *1003*

Registrar's No.

1. PLACE OF DEATH:

(a) County.....  
(b) City or town..... *St Louis*  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
  
(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)

2. USUAL RESIDENCE OF DECEASED:

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

3. (a) PRINT FULL NAME

*Fred Ray*

3. (b) If veteran, name war.....

3. (c) Social Security No.....

4. Sex..... *M* 5. Color or race..... *B* 6. (a) Single, widowed, married, divorced..... *Single*

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive.....

7. Birth date of deceased..... *June 6*  
(Month) (Day) (Year)

8. AGE: Years..... *54* Months..... Days..... (less than one day) hr. min.

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

MOTHER FATHER

10. Usual occupation.....

11. Industry or business.....

12. Name.....

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

14. Maiden name.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

18. (a) Signature of funeral director.....

(b) Address.....

19. (a) (Date received local registrar) (b) *J. F. Predeck* (Registrar's signature)  
*AUG 5 1945*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month..... Year..... *1945* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 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.....

Duration

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?

While at work?..... (Specify type of place) (e) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

25636