

FILED OCT 28 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 35498
8955

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. 1003		Registrar's No. _____		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		d. STREET ADDRESS (If rural, give location) 947 Maryville Ave.		
d. FULL NAME OF HOSPITAL OR INSTITUTION: Christian Hospital				d. STREET ADDRESS (If rural, give location) 947 Maryville Ave.				
3. NAME OF DECEASED a. (First) Louis			b. (Middle) Sylvester		c. (Last) Ray		4. DATE OF DEATH (Month) (Day) (Year) October 18, 1949	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH July 12, 1892		9. AGE (In years last birthday) 57	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 100 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Medical Depot		11. BIRTHPLACE (State or foreign country) Saginaw Michigan		12. CITIZEN OF WHAT COUNTRY? _____		
13a. FATHER'S NAME Cesar Ray			13b. MOTHER'S MAIDEN NAME _____		14. NAME OF HUSBAND OR WIFE Margaret			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME Margaret Ray ADDRESS 947 Maryville Ave.				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.				MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Praxeno Comosis ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cardio Vasculer Disease				INTERVAL BETWEEN ONSET AND DEATH 20 years
19a. DATE OF OPERATION none		19b. MAJOR FINDINGS OF OPERATION none				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT SUICIDE HOMICIDE (Specify) no		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) 114		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ m. _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 5233				
22. I hereby certify that I attended the deceased from Aug 20, 1949 , to Oct 18, 1949 , that I last saw the deceased alive on Oct 16, 1949 , and that death occurred at 4:30A. m. , from the causes and on the date stated above.								
23a. SIGNATURE Robert G. Warner, M.D. (Degree or title)				23b. ADDRESS Paul Brown Bldg.		23c. DATE SIGNED _____		
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 10-20-49	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		24d. LOCATION (City, town, or county) (State) St. Louis Missouri			
DATE REC'D BY LOCAL REG. OCT 18 1949		REGISTRAR'S SIGNATURE J. B. Easton		25. FUNERAL DIRECTOR'S SIGNATURE Chas. S. Smart		ADDRESS 1225 Union		

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed Clement M. Neary

Licensed Embalmer No. 3732

P. O. Address 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, fact should be so stated above.