

FILED JAN 7 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42883

State File No. 11191

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. _____

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis | |
| b. CITY (If outside corporate limits, write RURAL and give township) St. Louis | | c. CITY (If outside corporate limits, write RURAL and give township) St. Louis | |
| c. LENGTH OF STAY (in this place) 33 yrs | | d. STREET ADDRESS (If rural, give location) 4206 Finney Avenue (W) | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital | | | |

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|---|-------------|----------------------|--|
| 3. NAME OF DECEASED (Type or Print) a. (First) Ernest | b. (Middle) | c. (Last) Ray | 4. DATE OF DEATH (Month) (Day) (Year) Dec. 23 1949 |
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|--------------------|-------------------------------|---|--------------------------------------|---|--|---------------------------------------|
| 5. SEX Male | 6. COLOR OR RACE Negro | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov. 6, 1877 | 9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months 1 Days 17 | IF UNDER 24 HRS. Hours 17 Min. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houseman | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Lafayette, Alabama | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
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| 13a. FATHER'S NAME Unknown | 13b. MOTHER'S MAIDEN NAME Unknown | 14. NAME OF HUSBAND OR WIFE Willie Mae Ray |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Willie Mae Ray | ADDRESS 4206 Finney Ave. (W) |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i> | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage | | INTERVAL BETWEEN ONSET AND DEATH 2 days |
| | ANTECEDENT CAUSES DUE TO (b) Arteriosclerotic Heart Disease | | |
| | DUE TO (c) | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | | |

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| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
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| 21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Louis Mo. |
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| 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? 331A |
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22. I hereby certify that I attended the deceased from **12-21**, 1949, to **12-23**, 1949, that I last saw the deceased alive on **12-23**, 1949, and that death occurred at **12:30p** m., from the causes and on the date stated above.

| | | |
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| 23a. SIGNATURE James J. Hedrick (Degree or title) M. D. | 23b. ADDRESS 2601 N Whittier St | 23c. DATE SIGNED 12-24-49 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Dec. 30, 1949 | 24c. NAME OF CEMETERY OR CREMATORY Washington Park | 24d. LOCATION (City, town, or county) (State) St. Louis Co. Mo. |
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| DATE REC'D BY LOCAL REG. DEC 28 1949 | REGISTRAR'S SIGNATURE J. B. Suster | 25. FUNERAL DIRECTOR'S SIGNATURE J. H. Randle & Son | ADDRESS 3133 Bell Ave. |
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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 *S. J. Watson*

Licensed Embalmer No. *2698*

P. O. Address *2769 Christie*

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.