

FILED JUL 29 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 24587

6176

BIRTH NO. _____		REG. DIST. NO. <u>318</u>		PRIMARY REG. DIST. NO. <u>1003</u>		Registrar's No. _____					
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Illinois</u> b. COUNTY <u>St. Clair</u>							
b. CITY OR TOWN <u>ST. LOUIS</u>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <u>E. St. Louis</u>		8120					
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>BARNES HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>705 N. 32nd Str.,</u> 8							
3. NAME OF DECEASED (Type or Print) a. (First) <u>JESSE</u> b. (Middle) <u>LUTHER</u> c. (Last) <u>BRAY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>JULY 18, 1950</u>								
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 1, 1879</u>		9. AGE (In years last birthday) <u>70</u>	IF UNDER 1 YEAR Months _____	IF UNDER 1 YEAR Days _____	IF UNDER 1 YEAR Hours _____	IF UNDER 1 YEAR Min. _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L. C. Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Morgan Co., Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>					
13a. FATHER'S NAME <u>Unknown Bray</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>Alinda Bray</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. _____		17. INFORMANT'S SIGNATURE OR NAME <u>Mr. J. L. Bray</u>				ADDRESS <u>E. St. Louis</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)				MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>MYOCARDIAL INFARCTION</u>				DUE TO (b) <u>Arteriosclerotic Cardio-Vascular disease</u>				<u>18 days</u>			
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.				DUE TO (c) <u>Hypertensive Cardio-Vascular disease</u>				<u>6 yrs</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.											
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
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)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>420A</u>							
22. I hereby certify that I attended the deceased from <u>6/30/50</u> , 19 <u>50</u> , to <u>7/18</u> , 19 <u>50</u> , that I last saw the deceased alive on <u>7/18</u> , 19 <u>50</u> , and that death occurred at <u>12:33a</u> m., from the causes and on the date stated above.											
23a. SIGNATURE <u>Paul H. Wornon, M.D.</u>				(Degree or title)		23b. ADDRESS <u>Barnes Hospital</u>		23c. DATE SIGNED <u>7/18/50</u>			
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <u>July 20, 1950</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Mt. Hope</u>		24d. LOCATION (City, town, or county) (State) <u>Belleville, Illinois</u>					
DATE REC'D BY LOCAL REG. <u>JUL 18 1950</u>		REGISTRAR'S SIGNATURE <u>J. B. Basato</u>			FUNERAL DIRECTOR'S SIGNATURE <u>W. H. H. H.</u>					ADDRESS <u>E. St. Louis, Ill.</u>	

(Licensed Embalmer's Statement on Reverse Side)

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.....

.....  
working under my personal supervision.

Signed.....  
Student Embalmer

Signed.....

Student Embalmer No.....

Licensed Embalmer No. 2162

P. O. Address E. St. Louis Ill.

**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.