

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATHState File No. \_\_\_\_\_  
Registrar's No. **3322**BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Mo.</b> b. COUNTY _____		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis, Mo</b>		c. LENGTH OF STAY (In this place) _____	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b> <b>2039</b>		
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Mo. Pac. Hospital</b>			d. STREET ADDRESS (If rural, give location) <b>3171 Leola Ave.</b> <b>0</b>		
3. NAME OF DECEASED (Type or Print)	a. (First) <b>Clifford</b>	b. (Middle) <b>Albert</b>	c. (Last) <b>Ray</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>March 26, 1953</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>single</b>	8. DATE OF BIRTH <b>Dec. 25, 1899</b>	9. AGE (In years last birthday) <b>53</b>	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>clerk</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Mo. Pac. R.R. Co.</b>	11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? _____	
13a. FATHER'S NAME <b>Albert Ray</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Marti</b>		14. NAME OF HUSBAND OR WIFE _____	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. _____	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Mary Ray 3171 Leola Ave.</b>		
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) <b>Cerebro-vascular accident</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: DUE TO (b) <b>Art. Hypertension</b> DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS - Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>not known</b>
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) _____		21f. HOW DID INJURY OCCUR? <b>33IX</b>
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				
22. I hereby certify that I attended the deceased from <b>March 25, 1953</b> , to <b>March 26, 1953</b> , that I last saw the deceased alive on <b>March 26, 1953</b> , and that death occurred at <b>4:45 p.m.</b> , from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <b>[Signature]</b>		23b. ADDRESS <b>Mo. Pac. Hospital</b>		23c. DATE SIGNED <b>3-27-53</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24b. DATE <b>Mar. 30, 1953</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Valhalla Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis Co. Mo.</b>		
DATE REC'D BY LOCAL REG. <b>MAR 28 1953</b>	REGISTRAR'S SIGNATURE <b>J. Earl Smith, M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Kriegshauser 4228 S. Kingshighway Bl.</b>		

**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.

Student .....  
Student Embalmer

Student Embalmer No. \_\_\_\_\_  
Signed *Edwin M. Heruatt*  
Licensed Embalmer No. 3024

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.