

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **37521**  
**9998**

FILED OCT 29 1953

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** 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 <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips Hospital</b>		e. STREET ADDRESS (If rural, give location) <b>26 1829 N. Broadway</b> <span style="float: right;">2269</span>			

3. NAME OF DECEASED (Type or Print)	a. (First) <b>Willie</b>	b. (Middle) <b>Green</b>	c. (Last) <b>Ray</b>	4. DATE OF DEATH	(Month) <b>10</b>	(Day) <b>18</b>	(Year) <b>53</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>May 15, 1901</b>	9. AGE (In years last birthday) <b>52</b>	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 1 HR. Hours	IF UNDER 1 HR. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Mississippi</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
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13a. FATHER'S NAME <b>Ned Ray</b>	13b. MOTHER'S MAIDEN NAME <b>Ann Jackson</b>	14. NAME OF HUSBAND OR WIFE <b>Almeta Ray</b>
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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) <b>?</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <b>Almeta Ray 1829<sup>th</sup> Broadway</b>	ADDRESS
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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, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Prob. Aneurysm of Innominate Artery</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Undt.</b>
	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.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>022x</b>
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22. I hereby certify that I attended the deceased from **10-16**, 19**53**, to **10-18**, 19**53**, that I last saw the deceased alive on **10-18**, 19**53**, and that death occurred at **12:30P m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>Ed. B. Williams, M.D.</b>	23b. ADDRESS <b>2601 N. Whittier</b>	23c. DATE SIGNED <b>10-19-53</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removed</b>	24b. DATE <b>Oct 23/53</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis MO</b>
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DATE REC'D BY LOCAL REG. <b>OCT 20 1953</b>	REGISTRAR'S SIGNATURE <b>Chas. Smith</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. C. Green</b>	ADDRESS <b>4214 Delmar</b>
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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.....  
Signature of Student Embalmer

Signed *F. A. Green*

Licensed Embalmer No. *296*

P. O. Address *4214 Belmont*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.