

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 20 1954

29175

State File No.

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **7254**

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) OR TOWN St. Louis, Mo.		c. CITY OR TOWN Robertson	
c. LENGTH OF STAY (in this place)		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		e. STREET ADDRESS (If rural, give location) Fee Fee Road Rt. #1 Box 609	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) David	b. (Middle) NMN	c. (Last) Ray	(Month) August	(Day) 3	(Year) 1954
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec. 24, 1890	9. AGE (In years last birthday) 63	IF UNDER 1 YEAR Months Days IF UNDER 1 WEEK Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man		10b. KIND OF BUSINESS OR INDUSTRY Machine Shop		11. BIRTHPLACE (City and State or Foreign Country) Glasgow Scotland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Samuel Ray	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE Alice L. Ray
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. 489-03-9318	17. INFORMANT'S SIGNATURE OR NAME ADDRESS Alice L. Ray Rt. #1 Robertson, Mo.

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) Hemorrhage (Mackel's Diverticulum)		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hrs.	
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.. DUE TO (b) Chronic Obstructive Emphysema			10 yrs.
	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 checked="" type="checkbox"/> NO <input 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? 578X

22. I hereby certify that I attended the deceased from **July 26, 1954**, to **August 3, 1954**, that I last saw the deceased alive on **August 3, 1954**, and that death occurred at **7:30A m.**, from the causes and on the date stated above.

23a. SIGNATURE E. D. Vermillion M.D.	(Degree or title) M. D.	23b. ADDRESS BARNES HOSPITAL	23c. DATE SIGNED 7/3/54
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 6-6-54	24c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	24d. LOCATION (City, town, or county) (State) St. Louis, Missouri

DATE REC'D BY LOCAL REG. AUG 5 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE Collier Mortuary	ADDRESS 10123 St. Chas. Rd.
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(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, Student Embalmer No..... working under my personal supervision.:

Student.....
Signature of Student Embalmer

Signed..... *Sheldon Collins*.....

Licensed Embalmer No. *338*

P. O. Address *1012 3rd St Ch*

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.