

FILED OCT 26 1954

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **35406**
Registrar's No. **9192**

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 Missouri b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips Hospital		e. STREET ADDRESS (If rural, give location) 21 2526 Pine		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or Print) Mary		a. (First)	b. (Middle)	c. (Last) Gray	4. DATE OF DEATH (Month) 10 (Day) 4 (Year) 54	
---	--	------------	-------------	--------------------------	---	--

5. SEX M	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Dec 14, 1873	9. AGE (In years last birthday) 80	IF UNDER 1 YEAR Months 9	IF UNDER 12 HRS. Hours 4 Min.
-----------------	-------------------------------	--	---	--	------------------------------------	---

10a. USUAL OCCUPATION (Give kind of work during most of working life even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) Clarksdale, Miss	12. CITIZEN OF WHAT COUNTRY?
---	-----------------------------------	---	------------------------------

13a. FATHER'S NAME Taylor William	13b. MOTHER'S MAIDEN NAME Mary Small	14. NAME OF HUSBAND OR WIFE Kase Gray
---	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Kase Gray 2635 Pine	ADDRESS
--	--	---	---------

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.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis with Left Hemiplegia		Undt.
	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. Generalized Arteriosclerosis Decubitus Ulcers			

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? 332X
--	--	---

22. I hereby certify that I attended the deceased from **8-29**, 19**54**, to **10-4**, 19**54**, that I last saw the deceased alive on **10-4**, 19**54**, and that death occurred at **8:15A** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Edw. B. Williams M.D.	23b. ADDRESS 2601 N. Whittier	23c. DATE SIGNED 10-6-54
--	---	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE Oct. 11, 1954	24c. NAME OF CEMETERY OR CREMATORY Oakdale	24d. LOCATION (City, town, or county) (State) St. Louis, Mo.
---	-----------------------------------	--	--

DATE REC'D BY LOCAL REG. OCT 11 1954	REGISTRAR'S SIGNATURE J. Carl Smith	25. FUNERAL DIRECTOR'S SIGNATURE E. B. Kowace	ADDRESS 1221 N. Grand
--	---	---	---------------------------------

(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 *Gayton Swan*
Licensed Embalmer No. 458

P. O. Address 1221 7th

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.