

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 502 Registrar's No. 1225

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>(None)</u>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <u>Rural (Koch)</u>)	c. LENGTH OF STAY (In this place) <u>330 days</u>	c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Robert Koch Hospital</u>		e. STREET ADDRESS (If rural, give location) <u>3629a Laclede</u>	

3. NAME OF DECEASED (Type or Print)	a. (First) <u>HERMAN</u>	b. (Middle) <u>WALTER</u>	c. (Last) <u>GRAY</u>	4. DATE OF DEATH (Month) <u>May</u> (Day) <u>28</u> (Year) <u>1955</u>
-------------------------------------	--------------------------	---------------------------	-----------------------	--

5. SEX <u>Male</u>	6. COLOR (OR RACE) <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, <u>Separated</u>	8. DATE OF BIRTH <u>June 14, 1901</u>	9. AGE (In years, <u>54 yrs</u>)	IF UNDER 1 YEAR Months _____	IF UNDER 24 HRS. Hours _____ Min. _____
--------------------	---------------------------------	--	---------------------------------------	-----------------------------------	------------------------------	---

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical worker, testing motors</u>	10b. KIND OF BUSINESS OR INDUSTRY _____	11. BIRTHPLACE (City and State or Foreign Country) <u>Kansas City, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
--	---	---	--

13a. FATHER'S NAME <u>John Thomas Gray</u>	13b. MOTHER'S MAIDEN NAME <u>Maude Davis</u>	14. NAME OF HUSBAND OR WIFE <u>Aileene Moore</u>
--	--	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>489-09-6184</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Robert Koch Hospital Records</u>	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, asphyxia, 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) <u>Leukosarcoma (Lymphosarcoma cell leukemia) & multiple deposits</u>		<u>1-2 years</u>
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>deposits</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Pulmonary tuberculosis</u>		<u>1 1/2 years</u>	

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) _____	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? _____
---	--	----------------------------------

22. I hereby certify that I attended the deceased from April 1, 1955, to May 28, 1955, that I last saw the deceased alive on May 28, 1955, and that death occurred at 8:05p m., from the causes and on the date stated above.

22a. SIGNATURE <u>Joseph M. Schuster Jr MD</u> (Degree or title) _____	23b. ADDRESS <u>Robert Koch Hosp., Koch, Mo.</u>	23c. DATE SIGNED <u>5/29/55</u>
--	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24b. DATE <u>JUNE 2/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>MEMORIAL PARK CEM.</u>	24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MO.</u>
---	----------------------------	--	--

DATE REC'D BY LOCAL REG. <u>5/31/55</u>	REGISTRAR'S SIGNATURE <u>Herbert R. ...</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>John Stycar + Son</u>	ADDRESS <u>5541 Riverview</u>
---	---	---	-------------------------------

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.....
J. M. Patten

Licensed Embalmer No. 398

P. O. Address..... St. Louis

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.