

FILED MAR 22 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **11295****318**PRIMARY REG. DIST. NO. **1003**Registrar's No. **2063**

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| BIRTH NO. | | REG. DIST. NO. | | PRIMARY REG. DIST. NO. | | Registrar's No. | | | | | |
| 1. PLACE OF DEATH a. COUNTY | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Illinois b. COUNTY St. Clair | | | | | | | |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis | | c. LENGTH OF STAY (In this place) 2 days | | c. CITY OR TOWN Granite City | | 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 Lutheran Hospital | | | | e. STREET ADDRESS (If rural, give location) 3801 Pontoon Road | | | | | | | |
| 3. NAME OF DECEASED (Type or Print) | | | a. (First) Sarah | | | b. (Middle) Anna | | | | | |
| | | | c. (Last) Ray | | | 4. DATE OF DEATH (Month) (Day) (Year) Feb. 25, 1956 | | | | | |
| 5. SEX F | | 6. COLOR OR RACE W | | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed | | 8. DATE OF BIRTH May 7, 1867 | | 9. AGE (In years last birthday) 88 yrs. | | | |
| | | | | | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | | 11. BIRTHPLACE (City and State or Foreign Country) Fayette Co., ILL. | | | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13a. FATHER'S NAME John Lawler | | | 13b. MOTHER'S MAIDEN NAME Elvina Tate | | | 14. NAME OF HUSBAND OR WIFE Wm. Ray | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No none | | | 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT'S SIGNATURE OR NAME Mrs. Alleen Klippel | | | ADDRESS 524 Fair Oaks St. Louis, 17 Mo | | |
| 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, asthenia, etc. It means the disease, injury, or complication which caused death. | | | | MEDICAL CERTIFICATION | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days | | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction due to strangulated right femoral hernia | | | | 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. General arteriosclerosis 56:1 | | | | | | | | 5 yrs. | | | |
| 19a. DATE OF OPERATION 2-24-56 | | 19b. MAJOR FINDINGS OF OPERATION Intestinal obstruction due to strangulated right femoral hernia | | | | | | 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) | | | | | | |
| 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 2-21 , 19 56 , to 2-25 , 1956, that I last saw the deceased alive on Feb. 25 , 1956, and that death occurred at 8:15 pm. , from the causes and on the date stated above. | | | | | | | | | | | |
| 23a. SIGNATURE (Degree or title) B. W. Klippel, M.D. | | | | | 23b. ADDRESS 3701 Grandel Sq., St. Louis, Mo. | | | 23c. DATE SIGNED 2-27-56 | | | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | | 24b. DATE Feb. 26, 1956 | | 24c. NAME OF CEMETERY OR CREMATORY Union Cemetery | | | 24d. LOCATION (City, town, or county) (State) Sharon Twnsp. Fayette Co., Ill | | | | |
| DATE REC'D BY LOCAL REG. FEB 27 1956 | | REGISTRAR'S SIGNATURE Carl Smith | | | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Mr. Holt. Funeral Home Vandalia, Ill. | | | | | | |

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

7/23 3939

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.....
Jos. E. McCulloch

Licensed Embalmer No. 24

P. O. Address... 61752

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (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.