FILED FEB 25 1957

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

6228

Registration District No. 318 Primary Registration District No. 1003 STATE FILE NUMBER 790

Registrar's No.

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO. Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 04 BARNES HOSPITAL Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Illinois b. COUNTY
c. CITY OR TOWN Galatia 8120 8 Inside Limits Yes ☐ No ☐
d. STREET ADDRESS 32 (If outside, give location) Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First RICHARD Middle PAUL Last GRAY

4. DATE OF DEATH Month Day Year JAN. 22, 1957

5. SEX male 0

6. COLOR OR RACE white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH 9-4-1911

9. AGE (In years last birthday) 45 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) county clerk

10b. KIND OF BUSINESS OR INDUSTRY Civic

11. BIRTHPLACE (City and state or country) Illinois 1

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William J. Gray

14. MOTHER'S MAIDEN NAME Rhoda Parker

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT Address Chapman Bowles, Barnes Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Cerebral Aneurysm

INTERVAL BETWEEN ONSET AND DEATH 11 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)

DUE TO (c) 330 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐ 1

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from JAN. 13, 1957, to JAN. 22, 1957 and last saw her/him alive on JAN. 22, 1957
Death occurred at 8:35 P.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) C. R. Vermillion, M.D. M D. 0

22b. ADDRESS BARNES HOSPITAL

22c. DATE SIGNED 1/23/57

23a. BURIAL, CREMATION, REMOVAL (Specify) removal

23b. DATE 1-25-57

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county) (State) Galatia, Ill.

24. FUNERAL DIRECTOR ADDRESS Courtney, Galatia, Ill.

25. DATE RECD. BY LOCAL REG. JAN 25 '57

26. REGISTRAR'S SIGNATURE Earl Smith MD MJB

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed. Harvey Kahle

Licensed Embalmer No. 459

P. O. Address St Louis

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.