

Sent to me P.E.T.P. PA-7-56

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6547

FILED FEB 25 1957

13346-57

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

894

Registrar's No.

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Crawford</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Missouri</b>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <b>Bourbon</b>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Missouri Baptist Hospital</b>				Length of stay in 1b <b>1 day</b>		3/d. STREET ADDRESS (If outside, give location) <b>0280</b>	
3. NAME OF DECEASED (Type or print) First <b>Wendell</b> Middle <b>Gene</b> Last <b>Ray</b>				4. DATE OF DEATH Month <b>January</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1957</b>	
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <b>0</b>		IF UNDER 1 YEAR Months <b>15</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Infant - None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Nil</b>		11. BIRTHPLACE (City and state or country) <b>Sullivan, Missouri</b>	
13. FATHER'S NAME <b>Clark E. Ray</b>				14. MOTHER'S MAIDEN NAME <b>Barbara Lee Klonts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No Nil</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Clark E. Ray, Bourbon, Missouri.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Blood loss due to + rupture</b> <b>Cyathoblastous Ectopic</b> DUE TO (b) _____ DUE TO (c) _____ CONDITIONS if any, which give rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n) <b>770.0</b>							INTERVAL BETWEEN ONSET AND DEATH <b>15</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>770.0</b>			
20c. TIME OF INJURY Hour _____ Month _____ Day _____ Year _____ a. m. _____ p. m. _____							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <b>1-25-57</b> to <b>1-25-57</b> and last saw her alive on <b>1-25-57</b> Death occurred at <b>3:10</b> p. m. on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <b>Robert L. Horn MD</b>				22b. ADDRESS <b>8230 Lornyth</b>		22c. DATE SIGNED <b>1-25-57</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		23b. DATE <b>1-25-57</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cross Roads Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Leasburg, Missouri.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Albert H. Hoppe, 4700 Washington Blvd.,</b>				25. DATE RECD. BY LOCAL REG. <b>JAN 28 '57</b>		26. REGISTRAR'S SIGNATURE <b>Charles Smith MD</b>	

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.....  
*John S. Dennis*

Licensed Embalmer No. *71*

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.