

FILED JAN 13 1958

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **45853**  
Registrar's No. **12450**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>12450</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE _____ b. COUNTY _____					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>2 yrs.</b>		c. CITY OR TOWN <b>St. Louis</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>26 St. Louis Chronic Hosp.</b>				e. STREET ADDRESS (If rural, give location) <b>3307 Delmar</b>					
3. NAME OF DECEASED (Type or Print) a. (First) <b>Ethel</b>			b. (Middle) _____		c. (Last) <b>Gray</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>12-16-1957</b>		
5. SEX <b>female</b>		6. COLOR OR RACE <b>col.</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>widow</b>		8. DATE OF BIRTH <b>11-24-1890</b>		9. AGE (In years last birthday) <b>67</b> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 12 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (City and State or Foreign Country) <b>Tenn.</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>Kriss Johnson</b>			13b. MOTHER'S MAIDEN NAME <b>Edith ?</b>			14. NAME OF HUSBAND OR WIFE <b>unk.</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) _____		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Chronic Hospital Records</b> ADDRESS <b>5600 Arsenal</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) <i>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.</i>		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>St. middle cerebral art. thrombosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 yrs.</b>	
		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.							
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 <b>7-28-55</b> , 19____, to <b>12-16-57</b> , 19____, that I last saw the deceased alive on <b>12-16-57</b> , 19____, and that death occurred at <b>12:50 a.m.</b> from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>John W. Beckham, M.D.</b>				23b. ADDRESS <b>5800 Arsenal St.</b>		23c. DATE SIGNED <b>12/23/57</b>			
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		24b. DATE <b>12-27-57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>City Crematory</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>			
DATE REC'D BY LOCAL REG. <b>DEC 26 57</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith MD</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Frank O'Donnell</b>		ADDRESS <b>5600 Arsenal St.</b>			

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..

NOT EMBALMED      CREMATED BY CITY

Student.....  
Signature of Student Embalmer

Signed.....

Licensed Embalmer No.....

P. O. Address.....

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.