

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-010962

STATE FILE NUMBER

2 1975

FILED APR 6 1959 Registration District No. _____ Primary Registration District No. _____ Registrar 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, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN East St. Louis Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) 616 Converse Ave. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last JOHN WESLEY GRAY			4. DATE OF DEATH Month Day Year FEBRUARY 21, 1959		
---	--	--	--	--	--

5. SEX Male 2	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 10, 1903	9. AGE (In years last birthday) 55	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) Laborer	10b. KIND OF BUSINESS OR INDUSTRY Nat. Bearing Mat.	11. BIRTHPLACE (City and state or country) Carthage, Mississippi	12. CITIZEN OF WHAT COUNTRY? USA
---	---	--	--

13a. FATHER'S NAME JOHN A. GRAY	13b. MOTHER'S MAIDEN NAME MARY TRIPLETT	14. NAME OF HUSBAND OR WIFE LYDIA LOUISE GRAY
---	---	---

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. 489-07-3941	17. INFORMANT Lydia Louise Gray	Address 616 Converse E. St. Louis, Ill.
--	---	---	--

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 12 HOURS
---	--	---

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

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) NEPHROSCLEROSIS UNKNOWN DURATION		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
--	--	---

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.)
---	--

20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED WHILE AT <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 MARCH 14, 1953 to FEB. 21, 1959 and last saw her alive on FEB. 21, 1959 Death occurred at 11:08 A.M. m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>FR M... M. D.</i>	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 2/24/59
--	--	------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 2/26/59	23c. NAME OF CEMETERY OR CREMATORY Sunset Garden of Memory Stookey Township, Ill.	23d. LOCATION (City, town, or country) (State)
--	-----------------------------	---	--

24. FUNERAL DIRECTOR <i>W. Smith</i>	ADDRESS 2114 Mo. Ave. E. St. Louis, Ill.	DATE RECD. BY LOCAL REG. FEB 25 '59	26. REGISTRAR'S SIGNATURE <i>W. Smith M. D.</i>
---	---	---	--

300
1-57
3
E

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Frank Protap*

Licensed Embalmer No. *4356*

P. O. Address... *St. Louis, Mo.*

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.