

INDEXED

1. PLACE OF DEATH
 a. COUNTY
 b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN **St. Louis** Length of stay in 1b
 c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION **City Hospital** Inside Limits Yes No

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE **Mo.** b. COUNTY
 c. CITY OR TOWN **St. Louis** Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) **3448 St. Vincent Ave.** Reside on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last
CLAUDE D. RAYMOND

4. DATE OF DEATH Month Day Year
9/3/60

5. SEX **Male** 6. COLOR OR RACE **White** 7. Married Never Married
 Widowed Divorced

8. DATE OF BIRTH **1/30/94** 9. AGE (last birthday) **66 yrs.**

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Electrician (Retired)**
 10b. KIND OF BUSINESS OR INDUSTRY **Uninon Elec. Co.** 11. BIRTHPLACE (City and state or country) **Mode, Ill.**
 12. CITIZEN OF WHAT COUNTRY **USA**

13a. FATHER'S NAME **Raymond** 13b. MOTHER'S MAIDEN NAME **Mathilda Nichols** 14. NAME OF HUSBAND OR WIFE **Lillian Chalus Raymond**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes W.W.I**
 16. SOCIAL SECURITY NO. **551-16-8302** 17. INFORMANT Address **Lillian Raymond 3448 St. Vincent Av.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) **Fracture of Skull**
 DUE TO (b) **Subdural Hematoma**
 DUE TO (c)
 Conditions, if any, which gave 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 (a) **904.9-48**

PART III. If deceased was female was there a pregnancy in last 90 days.
 Yes No Unknown

19. WAS AUTOPSY PERFORMED? YES NO 20a. AGENT SUICIDE HOMICIDE
 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
Verdict time, place, cause and manner of same could not be determined

20c. TIME OF INJURY Hour 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 _____ to _____ and last saw her/him alive on _____
 Death occurred at _____ on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) **[Signature]** 22b. ADDRESS **1300 Clark St.** 22c. DATE SIGNED **9-6-60**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Removal** 23b. DATE **9/6/60** 23c. NAME OF CEMETERY OR CREMATORY **National** 23d. LOCATION (City, town, or county) (State) **Jefferson Barracks, Mo.**

24. FUNERAL DIRECTOR ADDRESS **E.J.Schnur 3125 Lafayette Ave.** 25. DATE RECD. BY LOCAL REG. **SEP 8 1960** 26. REGISTRAR'S SIGNATURE **[Signature]**

DOCUMENT

MEDICAL CERTIFICATION

AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

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

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Thomas R. Jenwick

Licensed Embalmer No. 3793

P. O. Address 3125 Laff

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