

SOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-019898-
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 1510

AMENDED

FILED JUN 6 1961

1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY St. Louis	a. STATE Missouri	b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Heights (17)	Length of stay in lb 4 Yrs.	c. CITY OR TOWN Richmond Heights (17)	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION res. #1 Hanley Downs	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) res. #1 Hanley Downs	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last MRS. ALMA DELACHMONT RAY			4. DATE OF DEATH Month Day Year May 28, 1961	
5. SEX F.	6. COLOR OR RACE W.	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Sept 27 1869	9. AGE (last birthday) 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (City and state or country) Chester, Illinois	12. CITIZEN OF WHAT COUNTRY USA
13a. FATHER'S NAME Dr. Arthur Penney		13b. MOTHER'S MAIDEN NAME Catherine Horn		14. NAME OF HUSBAND OR WIFE Matthias R. Ray
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. None	17. INFORMANT Address Mrs. Thomas J. Brew #1 Hanley Downs (17)	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Ch Myocarditis				1yr +
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Arterio Sclerosis			1yr +
	DUE TO (c) Senility		1yr +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 a.m. p.m.	Month, Day, Year		
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 7/6/1957 to 5/28/1961 and last saw her alive on 5/27/61
Death occurred at 11:02 A m of the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Robert P Smith MD	22b. ADDRESS 5203 Chippewa	22c. DATE SIGNED 5/29/61
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23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE 5/29/1961	23c. NAME OF CEMETERY OR CREMATORY Oak Grove Crematory	23d. LOCATION (City, town, or county) (State) St. Louis County, Missouri
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24. FUNERAL DIRECTOR ADDRESS Alexander & Sons, Inc. 6175 Delmar Blvd.	25. DATE RCD. BY LOCAL REG. 5-29-61	26. REGISTRAR'S SIGNATURE John B. Murphy MD
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DATE AMENDED

INSTEAD OF DOCUMENT

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

SHOULD READ

ITEM NO.

Dr. Herbert P. Smith
5203 Chippewa
FL 2 5200
12 to 4 Daily

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 J. Allen Davis
Licensed Embalmer No. 495

P. O. Address Albany
May 18 -

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.

Adverse

RECEIVED BY THE STATE BOARD OF HEALTH
DATE RECEIVED _____