ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-027889
STATE FILE NUMBER

AMENDED FILED JUL 19 1961

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 1909

1. PLACE OF DEATH a. COUNTY: St. Louis	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Missouri b. COUNTY: St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Normandy — Length of stay in 1b: 1 Day	c. CITY OR TOWN: Bel Ridge — Inside Limits: Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Normandy Osteopathic — Inside Limits: Yes ☑ No ☐	d. STREET ADDRESS (If outside, give location): 9200 Natural Bridge — Reside on Farm: Yes ☐ No ☑

3. NAME OF DECEASED (Type or print)	First: Ray	Middle: C.	Last: Spell	4. DATE OF DEATH	Month: July Day: 7, Year: 1961
5. SEX: Male	6. COLOR OR RACE: White	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH: 9-17-1913	9. AGE (last birthday): 47	IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HR: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-Employed	10b. KIND OF BUSINESS OR INDUSTRY: Horse Trader	11. BIRTHPLACE (City and state or country): Oxley, Missouri	12. CITIZEN OF WHAT COUNTRY: USA		
13a. FATHER'S NAME: Wallace Owen Spell	13b. MOTHER'S MAIDEN NAME: Emma McDaniels	14. NAME OF HUSBAND OR WIFE: Rose Spell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	17. INFORMANT Address: Rose Spell, 9115 Natrual Bridge				

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): Cardiac Arrest

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b): Myocardial Infarction

DUE TO (c): Coronary Occlusion — 7 hrs.

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. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ 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 7/7/61, to 7/7/61 and last saw him alive on 7/7/61

Death occurred at 7:15 p m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): D. A. Gardner MD	22b. ADDRESS: 917 Dupont Rd	22c. DATE SIGNED: 7/8/61
23a. BURIAL, CREMATION, REMOVAL (Specify): Removal	23b. DATE: 7/10/61	23c. NAME OF CEMETERY OR CREMATORY: Fairdealing
23d. LOCATION (City, town, or county) (State): Fairdealing, Mo.		
24. FUNERAL DIRECTOR ADDRESS: Earl Hilleman Overland, Mo.	25. DATE RECD. BY LOCAL REG.: 7-8-61	26. REGISTRAR'S SIGNATURE: John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED | INSTEAD OF | SHOULD READ | ITEM NO. | BY AFFIDAVIT OF | DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

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 _____

Licensed Embalmer No. 3501

P. O. Address Oakland

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