

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 891E STATE FILE NUMBER

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

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE Missouri b. COUNTY _____
 c. CITY OR TOWN St. Louis Inside Limits Yes No
 d. STREET ADDRESS (If outside, give location) 6112 Virginia Residence on Farm Yes No

3. NAME OF DECEASED (Type or print) First Middle Last Vesta T. Wray
4. DATE OF DEATH Month Day Year Sept. 25, 1961

5. SEX Male **6. COLOR OR RACE** white **7. Married** **Never Married**
Widowed **Divorced**
8. DATE OF BIRTH Sept. 28, 1881 **9. AGE (last birthday)** 79
 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) Ret. Clerk Government
10b. KIND OF BUSINESS OR INDUSTRY Kentucky **11. BIRTHPLACE** (City and state or country) Kentucky
12. CITIZEN OF WHAT COUNTRY USA

13a. FATHER'S NAME Ellen Reese Thos. H. Wray **13b. MOTHER'S MAIDEN NAME** Ellen Reese
14. NAME OF HUSBAND OR WIFE Ann C. Wray

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. unk. **17. INFORMANT** St. Louis, Mo.
Ann C. Wray 6112 Virginia

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
 PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) Cardiac failure INTERVAL BETWEEN ONSET AND DEATH 2 days
 DUE TO (b) Generalized atherosclerotic Cardio-
 DUE TO (c) Renal syndrome 442x 1 1/2 yr

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 1-25-49 to 9-25-61 and last saw her/him alive on 9-25-61
 Death occurred at 120 p.m. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) E. H. Wenthler M.D. **22b. ADDRESS** 5600 S Compton **22c. DATE SIGNED** 9-26-61

23a. BURIAL, CREMATION, REMOVAL (Specify) removal **23b. DATE** 9-28-61 **23c. NAME OF CEMETERY OR CREMATORY** Mt. Hope Cem. **23d. LOCATION** (City, town, or county) Lemay, Mo. (State) _____

24. FUNERAL DIRECTOR ADDRESS Southern Funeral Home 6322 S. Grand St. Louis, Mo. **25. DATE RECD. BY LOCAL REG.** SEP 26 1961 **26. REGISTRAR'S SIGNATURE** Loard Smith, M.D.

DATE AMENDED

INSTEAD OF DOCUMENT

SHOULD READ

BY AFFIDAVIT OF

DOCUMENT

MEDICAL CERTIFICATION

Dr. Withler
after noon
today

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 David Van Fossan

Licensed Embalmer No. 42112

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.