

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-042705

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **10815**

STATE FILE NUMBER

AMENDED

**FILED DEC 12 1961**

DATE AMENDED

INSTEAD OF

DOCUMENT

1. PLACE OF DEATH a. COUNTY _____		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MISSOURI</b> b. COUNTY _____	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS</b>		Length of stay in 1b <b>40 YRS.</b>	c. CITY OR TOWN <b>ST. LOUIS</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>D.O.A. HOMER-PHILLIPS HOSPITAL</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>4401-CLARENCE-AV.</b>
3. NAME OF DECEASED (Type or print) First Middle Last <b>RAYMOND MICHAEL</b>			4. DATE OF DEATH Month Day Year <b>NOV. 19TH 1961</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5-12-1907</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED: GUARD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT-DEPT</b>	9. AGE (last birthday) <b>54 YRS.</b>
11. BIRTHPLACE (City and state or country) <b>ILLINOIS</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13a. FATHER'S NAME <b>ALBERT-JESTER</b>		13b. MOTHER'S MAIDEN NAME <b>ADA-PEARL-KRONE</b>	14. NAME OF HUSBAND OR WIFE <b>JEAN-MICHAEL</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO NONE</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT Address <b>JEAN-MICHAEL-4401-CLARENCE-AV.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage caused by bullet wound entering the left ventricle filling the entire chest, both sides, full of blood, suffered when deceased shot self in home on Nov. 19, 1961, while suffering from temporary mental aberration.</b> 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). <b>Suicide 976x</b>			INTERVAL BETWEEN ONSET AND DEATH <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <b>see above</b>	
20c. TIME OF INJURY Hour a.m. p.m. <b>X</b>	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. CITY, TOWN, OR LOCATION <b>St. Louis, Mo.</b>	COUNTY STATE
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>4:00 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul G. Simon</b> (Degree or title) <b>Deputy Coroner</b>		22b. ADDRESS <b>1300 Clark</b>	22c. DATE SIGNED <b>11/21/61</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>NOV. 22-1961</b>	23c. NAME OF CEMETERY OR CREMATORY <b>SUNSET-BURIAL-PARK</b>	23d. LOCATION (City, town, or county) (State) <b>ST. LOUIS (COUNTY) MO.</b>
24. FUNERAL DIRECTOR ADDRESS <b>Brockland Und. Co. 1827-HOGAN-ST</b>		25. DATE RECD. BY LOCAL REG. <b>NOV 21 1961</b>	26. REGISTRAR'S SIGNATURE <b>Loed Smith, M.D.</b>

ITEM NO. SHOULD READ

BY 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 me,

of by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_

Signature of Student Embalmer.

Signed \_\_\_\_\_

*J W Winkley*

Licensed Embalmer No. 3653

P. O. Address J Pauline

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.