

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE
ON THIS STUD

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 3269

STATE FILE NUMBER

66 0013209

FILED APR 7 1966

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	
c. FULL NAME OF (If NOT in hospital, give location) <u>City Hospital No. 1</u>		d. STREET ADDRESS (If outside, give location) <u>2821 Franklin Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Percy</u> Middle <u>Rayford</u> Last		4. DATE OF DEATH Month <u>3</u> Day <u>26</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐	8. DATE OF BIRTH <u>9-5-1910</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
13a. FATHER'S NAME <u>George Cochran Rayford</u>		13b. MOTHER'S MAIDEN NAME <u>Leona Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Sadie Rayford-2821 Franklin Ave</u>		14. NAME OF HUSBAND OR WIFE <u>Sadie Rayford</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Reception of Pulmonary Aneurysm</u> DUE TO (b) <u>due to trauma with cardiac</u> DUE TO (c) <u>Kampnade</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>434.3</u>		INTERVAL BETWEEN ONSET AND DEATH <u>434.3</u>	
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 <u>3:30</u> a.m. <u>3:30</u> p.m.	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 <u>St. Louis</u> COUNTY <u>Mo.</u> STATE	
21. I attended the deceased from <u>2:30 A</u> to <u>3:30 A</u> and last saw her/him alive on <u>2:30 A</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <u>Helen L. Taylor, Coroner</u>		22b. ADDRESS <u>1300 Clark Ave.</u>	
22c. DATE SIGNED <u>3-29-66</u>		23. LOCATION (City, town, or county) (State) <u>St. Louis (County) Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>3/30/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Washington Park Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis (County) Mo.</u>
24. FUNERAL DIRECTOR <u>Ellis Funeral Home-2820 Stoddard St.</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 29 1966</u>	
26. REGISTRAR'S SIGNATURE <u>Joan Smith, M.D.</u>			

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

VS 300
Rev. 4/59

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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

L. B. Bryant

Licensed Embalmer No.

5261

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.