

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

29319

1. PLACE OF DEATH

County.....
Towship.....
City.....

Registration District No. 701
Primary Registration District No. 1003
(No. St. Marys Primary)

File No.....
Registered No. 8465
St..... Ward.....

2. FULL NAME

Joseph Ray
(a) Residence. No. Board of Childrens Building St. 22 Ward.

(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE MARRIED, WIDOWED OR DIVORCED (write the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) 6-4-1929

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>2</u>	<u>3</u>	<u>3</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work nurse 3¹¹ 15⁸
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) St Louis Mo.
(STATE OR COUNTRY)

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Alyce Ray

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Mo.
(STATE OR COUNTRY)

14. INFORMANT Alyce Ray
(Address) St. Louis Mo.

15. FILED _____ 19 Mar 2 1929
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

2 16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 7 1929
17. (4 45 am)

I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to Aug 7, 1929 that I last saw alive on Aug 7, 1929, and that death occurred, on the date stated above, at 4:45 am.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Massive
probably due to
Congenital syphilis
(duration) 2 mos. 2 ds.

CONTRIBUTOR (SECONDARY) Syphilis?
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED 3761 W Pine
IF NOT AT PLACE OF DEATH?

19. DID AN OPERATION PRECEDE DEATH? no DATE OF _____

20. WAS THERE AN AUTOPSY? yes
WHICH TEST CONFIRMED DIAGNOSIS? Wasserman & Mather
(Signed) M.D. Plate
_____ M. D.
_____ 19 29 (Address) St. Marys Primary

*State the DISEASE CAUSING DEATH, or in death from VIOLENCE, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL _____ DATE OF BURIAL 8-22-1929

20. UNDERTAKER E. Shanon 1426 Carroll
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

