

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH

791  
1008

8377  
Do not use this space.

2142

REC'D APR 12 1939

1. PLACE OF DEATH

(a) County ..... Registration District No. ....  
 (b) Township ..... Primary Registration District No. ....  
 (c) City St. Louis ..... (d) Street No. 3801 Gravois Ave. ..... St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

Carl Ray  
 (a) Residence, No. 3801 Gravois Ave. St. 16 (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Unk. Unk. 1885

7. AGE YEARS MONTHS DAYS If LESS than 1 day, ..... hrs. or ..... min.  
54 Unk. Unk.

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Gardner  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Arkansas

FATHER 13. NAME Unknown Ray

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER 15. MAIDEN NAME Unknown Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Sister Rose Virginie 3801 Gravois Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Calvary DATE Mar. 6 1939

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Arthur J. Donnelly 3840 Lindell Blvd.

20. FILED MAR 8 1939 J. F. Brudak Local Registrar

MEDICAL CERTIFICATE OF DEATH  
 21. DATE OF DEATH (MONTH, DAY, AND YEAR) Mar. 5, 1939

22. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....  
 I last saw h..... alive on ..... 19..... Death is said to have occurred on the date stated above, at 9:25 A.M.  
 The principal cause of death and related causes of importance were as follows:

Adyops Carcinoma of Stomach  
Remorhage  
 Other contributory causes of importance:

Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide? ..... Date of injury ..... 19.....  
 Where did injury occur? ..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury .....  
 Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? No  
 If so, specify .....  
 (Signed) Joseph M. Quinn  
 (Address) Deputy Coroner

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.

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed..... *Alfred J. Boedeker*

Licensed Embalmer No. *2663*

P. O. Address *4204 Prairie*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**