

FILED MAY 20 1949

 THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

 State File No. **17216**
 Registrar's No. **4183**

318

1003

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE Missouri b. COUNTY St. Louis 96			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (In this place) D		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN University City		3. _____	
d. FULL NAME OF HOSPITAL OR INSTITUTION Firman Desloge Hospital				d. STREET ADDRESS (If rural, give location) 1084 Wilson Ave.,			
3. NAME OF DECEASED (Type or Print) a. (First) MARY		b. (Middle) ELIZABETH		c. (Last) DUBRAY		4. DATE OF DEATH (Month) (Day) (Year) May 9, 1949.	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH Dec. 7, 1860	
9. AGE (In years last birthday) 88		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 12 HRS. Hours _____ Min. _____		11. BIRTHPLACE (State or foreign country) Florissant, Mo. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY _____		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Michael Teason	
13b. MOTHER'S MAIDEN NAME Don't Know		14. NAME OF HUSBAND OR WIFE Wm. E. DuBray		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT'S SIGNATURE OR NAME Charles Dubray		ADDRESS 1084 Wilson Ave.		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.			
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage from Cerebral Artery				INTERVAL BETWEEN ONSET AND DEATH 12 days		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Arteriosclerotic Cardiovascular Disease				DUE TO (c) _____		19a. DATE OF OPERATION _____	
19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____			
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) _____		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR? 4221				22. I hereby certify that I attended the deceased from April 29, 1949 , to May 9, 1949 , that I last saw the deceased alive on May 8, 1949 , and that death occurred at 10:20 AM on the causes and on the date stated above.			
23a. SIGNATURE J. O. Brown M.D.		(Degree or title) _____		23b. ADDRESS 1325 S. Grand Blvd.		23c. DATE SIGNED 5/10/49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE May 12, 1949		24c. NAME OF CEMETERY OR CREMATORY St. Ferdinand Cem.		24d. LOCATION (City, town, or county) (State) Florissant, Mo.	
DATE RECD BY LOCAL REGISTRY MAY 10 1949		REGISTRAR'S SIGNATURE J. B. Pascoe		25. FUNERAL DIRECTOR'S SIGNATURE Jos. W. Clark		ADDRESS 1125 Hodiamont Ave.	

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

Dr. Brown
DeSlouge Hosp.
11-5 P.M.

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
Student Embalmer

Signed *Alfred J. Boedeker*

Licensed Embalmer No. 2663

P. O. Address 1125 Hodiament Ave.,

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 this body is not embalmed, fact should be so stated above.