

FILED JUL 30 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 25204
Registrar's No. 6240

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo.	
b. CITY OR TOWN St. Louis		b. COUNTY Mo.	
c. LENGTH OF STAY (in this place)		c. CITY OR TOWN St. Louis	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4946 Cote Brillante		STREET ADDRESS (If rural, give location) 4946 Cote Brillante Ave.	

3. NAME OF DECEASED (Type or Print) John Milford Raymond	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH July 17 1949
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH May 29 1902	9. AGE (In years last birthday) 47	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mins.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Purchasing Agent	10b. KIND OF BUSINESS OR INDUSTRY Globe-Democrat	11. BIRTHPLACE (State or foreign country) Clarksville Mo.	12. CITIZEN OF WHAT COUNTRY?
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13a. FATHER'S NAME William Raymond	13b. MOTHER'S MAIDEN NAME Lucy Gladney	14. NAME OF HUSBAND OR WIFE Elizabeth Raymond
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. 489-07-7220	17. INFORMANT'S SIGNATURE OR NAME Elizabeth Raymond, 4946 Cote Br.	ADDRESS
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 months
	i. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) coronary artery sclerosis		
ii. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		DUE TO (c)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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) (STATE) Clarksville Mo. 9/18/49
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? H 201
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22. I hereby certify that I attended the deceased from Feb 25, 1948, to July 17, 1949, that I last saw the deceased alive on July 13, 1949, and that death occurred at 12 P. m., from the causes and on the date stated above.

23a. SIGNATURE Samuel B. Grant	(Degree or title) M.D.	23b. ADDRESS 114 N. Taylor Ave.	23c. DATE SIGNED 7/18/49
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 7/19/49	24c. NAME OF CEMETERY OR CREMATORY Clarksville	24d. LOCATION (City, town, or county) (State) Clarksville Mo.
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DATE REC'D BY LOCAL REG. JUL 18 1949	REGISTRAR'S SIGNATURE J. B. Sosate	25. FUNERAL DIRECTOR'S SIGNATURE Drehmann-Harrel	ADDRESS 1905 Union Blvd.
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(Licensed Embalmer's Statement on Reverse Side)

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

JAN 13 1950

11-57

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.

Signed Albert R. Thompson

Signed _____
Student Embalmer

Licensed Embalmer No. 4237

P. O. Address St. Louis

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.