

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 2476

FILED JAN 30 1956

BIRTH NO. _____ REG. DIST. NO. 310 PRIMARY REG. DIST. NO. 3058 Registrar's No. 42

1. PLACE OF DEATH a. COUNTY <u>St Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before institution). a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, write RURAL and give township) <u>St Charles</u>		c. CITY OR TOWN <u>Maryland Heights</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>12 hrs</u>		e. STREET ADDRESS (If rural, give location) <u>Weldon Lane</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St Joseph Hospital</u>		<u>7000</u>	

3. NAME OF DECEASED (Type or Print) a. (First) <u>William</u> b. (Middle) _____ c. (Last) <u>Ray</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 24 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 12 1867</u>
9. AGE (In years last birthday) <u>89</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Indiana</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

13a. FATHER'S NAME <u>Sam Ray</u>	13b. MOTHER'S MAIDEN NAME <u>Unknown</u>	14. NAME OF HUSBAND OR WIFE <u>unknown</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'S SIGNATURE OR NAME ADDRESS <u>Albert Ray Maryland Heights Mo</u>

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 <u>- 2 months</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Prostatic Tumor type unold</u> <u>Cerebral aneurysm</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>arteriosclerosis</u> DUE TO (c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>334x</u>			

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) (STATE)
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?

22. I hereby certify that I attended the deceased from 10 Nov, 1955, to 24 Jan, 1956 that I last saw the deceased alive on 23 Jan, 1956 and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>H. E. Hengen M.D.</u>	23b. ADDRESS <u>Pattersonville</u>	23c. DATE SIGNED <u>24 Jan 56</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	24b. DATE <u>Jan. 27 1956</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Cabool Cemetery</u>
		24d. LOCATION (City, town, or county) (State) <u>Cabool Mo</u>

DATE REC'D BY LOCAL REG. <u>Jan 24 1956</u>	REGISTRAR'S SIGNATURE <u>Fannie Hamilton</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Arthur C. Paul St. Charles Mo</u>
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(Licensed Embalmer's Statement on Reverse Side)

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

9561 9 T 1944

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.....
[Handwritten Signature]

Licensed Embalmer No. *3151*

P. O. Address *[Handwritten Address]*

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.