

Health,
& Welfare
Public
Service

FILED DEC 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59312-57

45854

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

11738

300
1-57

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN <u>St Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>W.D.A. Home G.</u>			Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <u>2110 10267 N. Whittier</u>		Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sharron</u> Middle <u>Gray</u> Last <u>Gray</u>				4. DATE OF DEATH Month <u>11</u> Day <u>30</u> Year <u>57</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 17, 1957</u>		9. AGE (In years last birthday) <u>3 mo.</u>	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Child</u>	11. BIRTHPLACE (City and state or country) <u>St Louis Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		
13a. FATHER'S NAME <u>Edwin Gray</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth Kemell</u>		14. NAME OF HUSBAND OR WIFE <u>Child</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>		Address <u>Edwin L. Gray 10267 N. Whittier</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation</u>							INTERVAL BETWEEN ONSET AND DEATH <u>E924.98</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	DUE TO (c)	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (Not reported to the clinical disease conditions given in Part I.) <u>After child's face was so buried in mother's hand & covered with blanket while sleeping with parents at 10267 N. Whittier Street on 11/30/57.</u>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Give nature of injury in PART I or PART II of item 18.) <u>Child's face was so buried in mother's hand & covered with blanket while sleeping with parents at 10267 N. Whittier Street on 11/30/57.</u>						
20c. TIME OF INJURY Hour <u>11</u> Month, Day, Year <u>30. 1957</u> o.m. <u>05</u> p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. CITY, TOWN, OR LOCATION <u>St Louis Mo</u>		
21. I attended the deceased from <u>1957</u> to <u>1957</u> and last saw her alive on <u>12/6/57</u> Death occurred at <u>1957</u> on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <u>Daniel Taylor Casner</u>				22b. ADDRESS <u>1300 Clark</u>		22c. DATE SIGNED <u>12-6-57</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>12-6</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Father Dixon</u>		23d. LOCATION (City, town, or county) (State) <u>Hickwood Mo</u>			
24. FUNERAL DIRECTOR <u>A. H. Burko</u>		ADDRESS <u>3506 Franklin</u>	25. DATE RECD. BY LOCAL REG. <u>DEC. 6 '57</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith Mo</u>			

(Licensed Embalmer's Statement on Reverse Side)

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 *W. H. Beck*
W. H. Beck
Licensed Embalmer No.
P. O. 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.