

Health, & Welfare
Public Health Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038141
STATE FILE NUMBER
REGISTRAR'S NO. 9260

FILED OCT 27 1958

Registration District No. 318 Primary Registration District No. 1003

S. 300
v. 1-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
MEDICAL CERTIFICATION
Disease in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY ST. LOUIS	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN RIVERVIEW GARDENS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION MO. BAPTIST		d. STREET ADDRESS (If outside city limits) 360 SCENIC DR	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST LUNA D. RAY		4. DATE OF DEATH Month Day Year 9 24 1958	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 13, 1887
9. AGE (In years last birthday) 71	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (City and state or country) BOLIVAR, TENN.
12. CITIZEN OF WHAT COUNTRY? USA	13a. FATHER'S NAME EUGENE MASHBURN	13b. MOTHER'S MAIDEN NAME CATHERINE CLIFFT	14. NAME OF HUSBAND OR WIFE RICHARD RAY
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address 360 SCENIC DR. GRACE SCHEURMANN RIVERVIEW GARDENS	
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>Cerebral thrombosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) <u>4201</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		
20c. TIME OF INJURY _____	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>9/11/58</u> to <u>9/24/58</u> and last saw her alive on <u>9/24/58</u> Death occurred at <u>7:25 PM</u> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>J. W. Holler, M.D.</u> (Degree or title)	22b. ADDRESS <u>5220 W. Webster</u>	22c. DATE SIGNED <u>9/26/58</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 9-26-1957	23c. NAME OF CEMETERY OR CREMATORY FRIEDENS	23d. LOCATION (City, town, or country) (State) ST. LOUIS, MO.
24. FUNERAL DIRECTOR ADDRESS SUEDEMEYER & SONS 3934 N. 20TH ST.	25. DATE RECD. BY LOCAL REG. SEP 26 1958	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.	

(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 *Gustav W. Dieterle*

Licensed Embalmer No. *4329*

P. O. Address *St. Louis, Mo.*

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.