

FEDERAL BUREAU OF INVESTIGATION - DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-021723

FILED VS. JUN 15 1960

318

1003

5734

STATE FILE NUMBER

Registration District No. _____ Primary Registration District 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 Wayne	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN Coldwater	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location)	

3. NAME OF DECEASED (Type or print) First MARY Middle F. Last WRAY			4. DATE OF DEATH Month JUNE Day 1 Year 1960		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1895	9. AGE (last birthday) 64	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Wayne Co., Mo.	
10c. CITIZEN OF WHAT COUNTRY U.S.		13a. FATHER'S NAME Unknown		13b. MOTHER'S MAIDEN NAME Martha Moore	
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 JoAnn Allen, Robertsville, Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL VASCULAR HEMORRHAGE		INTERVAL BETWEEN ONSET AND DEATH 2-3 DAYS
DUE TO (b) ESSENTIAL HYPERTENSION WITH ARTERIOSCLEROSIS		
DUE TO (c) 331X		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" 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 Hour _____ Month, Day, Year _____ a.m. _____ 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.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	

21. I attended the deceased from **AUG. 6, 1954** to **JUNE 1, 1960** and last saw her/him alive on **JUNE 1, 1960**
Death occurred at **7:30 P.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>E. Demillia, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 6/2/60
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23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 6-4-60	23c. NAME OF CEMETERY OR CREMATORY Local Cemetery	23d. LOCATION (City, town, or county) Coldwater, Mo.
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24. FUNERAL DIRECTOR Albert H. Hoppe, Inc., 4700 Washington Blvd.	25. DATE RECD. BY LOCAL REG. JUN 3 1960	26. REGISTRAR'S SIGNATURE <i>Joan Smith, M.D.</i>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

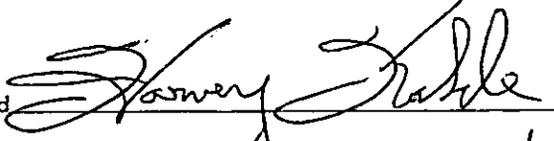
mjc

JANUARY 1954

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed 

Licensed Embalmer No. 4596

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not-embalmed, fact should be so stated above.