

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 <b>Missouri.</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis, Mo.</b>		c. CITY OR TOWN <b>St. Louis.</b>	
Length of stay in 1b		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Enroute City Hospital</b>		d. STREET ADDRESS (If outside, give location) <b>1718a Franklin, Ave.</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED <b>AKAS</b> First <b>Roxie Ann</b> Middle <b>Rudy</b> Last <b>Gray</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>5,</b> Year <b>1960</b>		
(Type or print) <b>Anna</b>					

5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>11/9/1889</b>	9. AGE (last birthday) <b>70</b>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	11. BIRTHPLACE (City and state or country) <b>Kentucky</b>	12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
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13a. FATHER'S NAME <b>Willie Reeves</b>	13b. MOTHER'S MAIDEN NAME <b>Elizabeth Weathers</b>	14. NAME OF HUSBAND OR WIFE <b>Unknown</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>	16. SOCIAL SECURITY NO. <b>500-30-2091</b>	17. INFORMANT <b>Mary Lou Scott, 1625 Marshall, Ct.</b>	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b>		<b>Artery</b>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <b>HYPERTENSION 331X</b>	<b>Chronic</b>
	DUE TO (c) <b>ARTERIOSCLEROSIS</b>	<b>Chronic</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>Rheumatoid Arthritis</b>		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

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.)
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year
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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
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21. I attended the deceased from **June 1956** to **Sept 3, 1960** and last saw her/him alive on **9-3-60**  
Death occurred at **8:40 A.M.** m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <b>May Grobenson, M.D.</b>	(Degree or title)	22b. ADDRESS <b>508 N. Grand</b>	22c. DATE SIGNED <b>9-22-60</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>9-23-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>	23d. LOCATION (City, town, or county) <b>St. Louis County, Mo.</b>
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24. FUNERAL DIRECTOR <b>Albert H. Hoppe Inc., 4700 Washington, Blvd.</b>	ADDRESS	25. DATE RECD. BY LOCAL REG. <b>SEP 22 1960</b>	26. REGISTRAR'S SIGNATURE <b>Loard Smith, M.D.</b>
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DOCUMENT

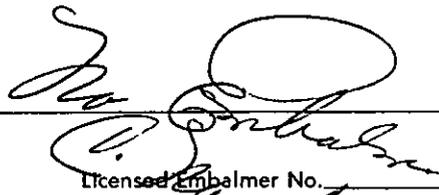
MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**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. \_\_\_\_\_

P. O. Address \_\_\_\_\_

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.