

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

APR 7 1961 AMENDED Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 2935 -61-011422 STATE FILE NUMBER

DATE AMENDED  
 INSTEAD OF  
 DOCUMENT  
 MEDICAL CERTIFICATION  
 SHOULD READ  
 BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>---</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>---</u>									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>7 yrs</u>		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>Masonic Home of Mo.</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>1511 DeSoto Ave.</u> <del>XXXXXX XXXXX</del>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <input checked="" type="checkbox"/> <u>(Susan)</u> Last <u>A. Raven</u>				4. DATE OF DEATH Month <u>March</u> Day <u>25</u> Year <u>1961</u>									
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH <u>2/1/77</u>		9. AGE (last birthday) <u>84</u>		IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>		IF UNDER 24 HR Hours <u>---</u> Min. <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>---</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (City and state, or country) <u>Quincy, Ill.</u>			12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>					
13a. FATHER'S NAME <u>Reuben Yocum</u>				13b. MOTHER'S MAIDEN NAME <u>Margaret Campbell</u>				14. NAME OF HUSBAND OR WIFE <u>Hugo L. Raven</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>---</u>						17. INFORMANT <u>Masonic Home of Missouri</u> Address <u>---</u>							
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) <u>Chronic Myocarditis</u>										<u>3 mo</u>			
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>Generalized Arteriosclerosis</u>										<u>unk</u>			
DUE TO (c) <u>Chronic Phlebothrombosis</u>										<u>2 mo</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>---</u>								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 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.) <u>---</u> <u>4221</u>					
20c. TIME OF INJURY Hour <u>---</u> a.m. <u>---</u> p.m. <u>---</u>		Month <u>---</u> Day <u>---</u> Year <u>---</u>		---		---		---					
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>---</u>			20f. CITY, TOWN, OR LOCATION <u>---</u>			COUNTY <u>---</u>		STATE <u>---</u>		
21. I attended the deceased from <u>3/1/54</u> to <u>3/25/61</u> and last saw her <u>max</u> alive on <u>3/25/61</u> Death occurred at <u>1:05 am</u> on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <u>Harold E. Walters MD</u>						22b. ADDRESS <u>3720 Washington St. St. Louis Mo.</u>				22c. DATE SIGNED <u>3-26-61</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE <u>3/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oak Grove</u>				23d. LOCATION (City, town, or county) <u>St. Louis County Mo.</u>					
24. FUNERAL DIRECTOR <u>John L. Ziegenhein &amp; Sons, 7027 Gravois</u>					ADDRESS <u>---</u>		25. DATE RECD. BY LOCAL REG. <u>MAR-28 1961</u>		26. REGISTRAR'S SIGNATURE <u>Loard Smith. M.D.</u>				

**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: Donald Biny

Licensed Embalmer, No. 2863

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.