

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE XC 1625085

SL-23957

9469 -62-036194
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **9469**

FILED OCT 1 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY Macoupin	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST LOUIS		Length of stay in 1b 11 HRS	c. CITY OR TOWN Girard Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VET ADM HOSPITAL		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 610 S. 4TH STREET Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ALBERT Middle Last GRAY		4. DATE OF DEATH Month OCTOBER Day 2 Year 1962	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 8-22-88
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY Farming	9. AGE (last birthday) 74 IF UNDER 1 YEAR: Months Days Hours Min.
11a. FATHER'S NAME ALFRED GRAY		11b. MOTHER'S MAIDEN NAME MARY SMITH	
12a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES		12b. SOCIAL SECURITY NO. WWW	
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME	
14a. NAME OF DECEASED		14b. NAME OF HUSBAND OR WIFE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) YES		16. SOCIAL SECURITY NO. WWW	
17. INFORMANT		Address CLEO GRAY 610 S 4TH Girard, ILL.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VASCULAR COLLAPSE DUE TO (b) ARRHYTHMIA DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE 4200			INTERVAL BETWEEN ONSET AND DEATH
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 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.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	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 10-1-62 to 10-2-62 and last saw him alive on 10-2-62 Death occurred at 4:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) James R. Ruff M.D.		22b. ADDRESS VAH, ST. LOUIS, MISSOURI	22c. DATE SIGNED 10/2/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 10-3-62	23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery	23d. LOCATION (City, town, or county) (State) Macoupin County, Illinois.
24. FUNERAL DIRECTOR Shane Funeral Home, Girard, Illinois.		25. DATE RECD. BY LOCAL REG. OCT 3 1962	26. REGISTRAR'S SIGNATURE Coan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

ITEM NO. SHOULD READ

BY AFFIDAVIT OF MEDICAL CERTIFICATION

DATE AMENDED

VS 300 Rev. 4/59

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28/20/27

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DOCUMENT

OK Helen P. Taylor
Dorner 10-3-62

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 J. W. M. Dinkley
Licensed Embalmer No. 3653
P. O. Address 1121 1/2 Ave. f. W.

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.