

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

11116-62-044757
STATE FILE NUMBER

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. _____

FILED NOV 26 1962

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		c. CITY OR TOWN St. Louis	
Length of stay in 1b 15 Yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP.#1		d. STREET ADDRESS (If outside, give location) 2820 Wisconsin	
Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle L. Last RAY			4. DATE OF DEATH Month 11 Day 18 Year 62
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 1/10/00
9. AGE (last birthday) 62		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HR Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dock worker		10b. KIND OF BUSINESS OR INDUSTRY So. Plaza Co.	11. BIRTHPLACE (City and state or country) Missouri
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Jim Ray	
13b. MOTHER'S MAIDEN NAME Mary Liggitt		14. NAME OF HUSBAND OR WIFE Eula Ray	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address Eula Ray, 2820 Wisconsin, St. Louis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Total occlusion of internal Carotid arteries Bilateral DUE TO (b) _____ DUE TO (c) 332x Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			
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
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 _____ 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 11/2/62 to 11/18/62 and last saw her/him alive on 11/18/62 Death occurred at 12:55 AM m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>[Signature]</i> (Degree or title)		22b. ADDRESS 1515 LAFAYETTE AVE.	22c. DATE SIGNED 11/18/62
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/21/62	22c. NAME OF CEMETERY OR CREMATORY St. Trinity	23d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
24. FUNERAL DIRECTOR McLaughlin, 2301 Lafayette,		25. DATE RECD. BY LOCAL REG. NOV 19 1962	26. REGISTRAR'S SIGNATURE <i>[Signature]</i> M.D.

MEDICAL CERTIFICATION

DOCUMENT

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

BY AFFIDAVIT OF

SCHEMTE
USE BLACK INK OR TYPEWRITER RIBBON

VS 300 Rev. 4/59
1
2 **22**
3
4 **0**
5 **1**
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7 **0**
8 **2**
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12 **75-0**
13

75

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,

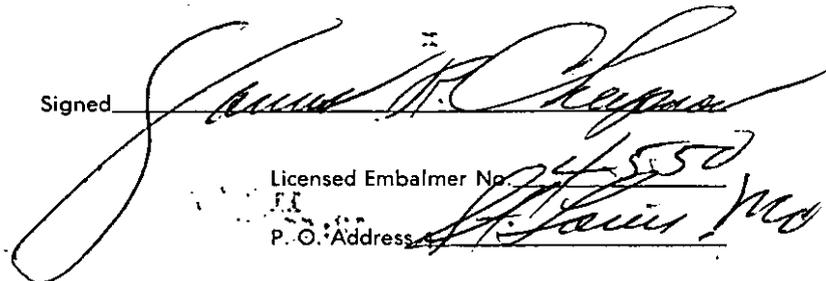
or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed



Licensed Embalmer No. 24550

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.