

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-026297

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **6952**

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED JUL 12 1963

VS 300 Rev. 4/59	DATE AMENDED	DOCUMENT	MEDICAL CERTIFICATION	BY AFFIDAVIT OF	1	2	3	4	5	6	7	8	9	10	11	12	13				
2					3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
3					4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
4					5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
5					6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22
6					7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
7					8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
8					9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
9					10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26
10					11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27
11					12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
12					13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29
13					14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri		b. COUNTY St. Louis		c. CITY OR TOWN Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b		c. CITY OR TOWN Saint Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4954 West Pine				
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 4954 West Pine		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 4954 West Pine		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) JOSEPHINE LEE RAY			4. DATE OF DEATH Month July Day 3 Year 1963			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 May 20-1878			9. AGE (last birthday) 85			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) at home				10b. KIND OF BUSINESS OR INDUSTRY Unknown				11. BIRTHPLACE (City and state or country) U.S.A.				
13a. FATHER'S NAME William Henri Lee				13b. MOTHER'S MAIDEN NAME Matilda McCartney				14. NAME OF HUSBAND OR WIFE Samuel G. Ray				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no none				16. SOCIAL SECURITY NO. [redacted]				17. INFORMANT Address Mrs. Chase Kimball-Pomfret Center Conn.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.04 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Carcinoma of Breast 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 1950 to July 1963 and last saw her alive on 27 June 1963 Death occurred at 7:00 AM on the date stated above, and to the best of my knowledge, from the causes stated.												
22a. SIGNATURE (Degree or title) Benjamin H. Clark, Jr. M.D.				22b. ADDRESS 3720 Washington - St. Louis				22c. DATE SIGNED July 1963				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7-5-1963		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery				23d. LOCATION (City, town, or county) (State) St. Louis Missouri				
24. FUNERAL DIRECTOR ADDRESS Lupton Chapel Inc. 7233 Delmar Blv'd.				25. DATE RECD. BY LOCAL REG. JUL 3 1963		26. REGISTRAR'S SIGNATURE Paul Smith, M.D.						

CITY OF Ray
Dr. B. Stevens
1000 Pa. Ave.
Ray, Mo. 64581
March 19, 1958

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 Clarence H. Murray

Licensed Embalmer No. 404

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.