

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-037591

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 9333 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED SEP 28 1963

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. LOUIS</u>		Length of stay in lb <u>7 1/2</u> Hours	c. CITY OR TOWN <u>ST. LOUIS (Overland)</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>ST. LOUIS-LITTLE ROCK HOSPITAL, INC.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS <u>3016 PASTEUR</u> (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Melda (Melda) ESTHER GRAY</u>			4. DATE OF DEATH Month Day Year <u>SEPTEMBER 15, 1963</u>
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-28-1902</u>
9. AGE (last birthday) <u>60</u>		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) <u>NOT EMPLOYED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	11. BIRTHPLACE (City and state or country) <u>Neelyville Missouri</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13a. FATHER'S NAME <u>James M. Scott</u>	
13b. MOTHER'S MAIDEN NAME <u>Laura Geisel</u>		14. NAME OF HUSBAND OR WIFE <u>ROBERT ROY GRAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates) <u>no none</u>		16. SOCIAL SECURITY NO. <u>1</u>	17. INFORMANT <u>Mr Robert R. Gray 3016 Pasteur Avenue</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Cerebral Hemorrhage</u> <u>Hypertension</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>331X</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>
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 Month, Day, Year a.m. p.m.		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 <u>1961</u> to <u>SEPT. 15, 1963</u> and last saw her alive on <u>Aug 30 1963</u> Death occurred at <u>9:10 AM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>9-16-63</u>	
22a. SIGNATURE <u>Island E. Harts MD</u> (Degree or title)		22b. ADDRESS <u>1755 S. Grand Blvd.</u>	22c. DATE SIGNED <u>9-16-63</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Sept 18, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Louis, Missouri</u> (State)
24. FUNERAL DIRECTOR <u>Shepard Funeral Home, St. Louis, Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>SEP 17 1963</u>	26. REGISTRAR'S SIGNATURE <u>Kean Smith, R.D.</u>

DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 BY AFFIDAVIT OF
 ITEM NO. SHOULD READ

VS 300 Rev. 4/59
 1
 2 4008
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 4 1
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 69
 USE BLACK INK OR TYPEWRITER RIBBON

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,

on/by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Louanna O. Gering*

Licensed Embalmer No. 4979

P. O. Address Berkeley, 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.