

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

8814

**1. PLACE OF DEATH**

County Buchanan

Registration District No. 85

File No. 240

Township St. Joseph

Primary Registration District No. 1001

Registered No. 240

City St. Joseph

(No. St. Joseph Hospital)

St.                      Ward                     

**2. FULL NAME** Lillian D. Gregory

(a) Residence. No. Stewartsville Mo. St.                      Ward                     

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female      4. COLOR OR RACE white      5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thomas Gregory

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov. 16 1874

|        |           |          |           |  |
|--------|-----------|----------|-----------|--|
| 7. AGE | YEARS     | MONTHS   | DAYS      | IF LESS than 1 day, .....hrs. or .....min. |
|        | <u>56</u> | <u>4</u> | <u>18</u> |  |

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work. Housewife <sup>235</sup>  
(b) General nature of industry, business, or establishment in which employed (or employer).....  
(c) Name of employer.....

9. BIRTHPLACE (CITY OR TOWN) Dekalb  
(STATE OR COUNTRY) Mo.

10. NAME OF FATHER George Williams

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Hempfle  
(STATE OR COUNTRY) Mo.

12. MAIDEN NAME OF MOTHER Lilly Williams

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Dekalb  
(STATE OR COUNTRY) Mo.

14. INFORMANT Thomas Gregory  
(Address) Stewartsville, Mo.

15. FILED 3-5-31 19 John R. Bender REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Mar. 4 1931

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27, 1931, to March 4, 1931, that I last saw him alive on March 4, 1931, and that death occurred, on the date stated above, at 7:30 P. m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Hypertension with metastasis to vena cava & retroperitoneal lymph glands (duration) 1 yrs. mos. ds.

CONTRIBUTORY (SECONDARY) Shock - Surgical  
(duration) 534 yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH Stewartsville Mo

1 DID AN OPERATION PRECEDE DEATH. yes DATE OF 3/4/31

WAS THERE AN AUTOPSY? yes

WHAT TEST CONFIRMED DIAGNOSIS Autopsy + operation

(Signed) J. Thompson M. D.

3/5, 1931 (Address) 825 Clark Street

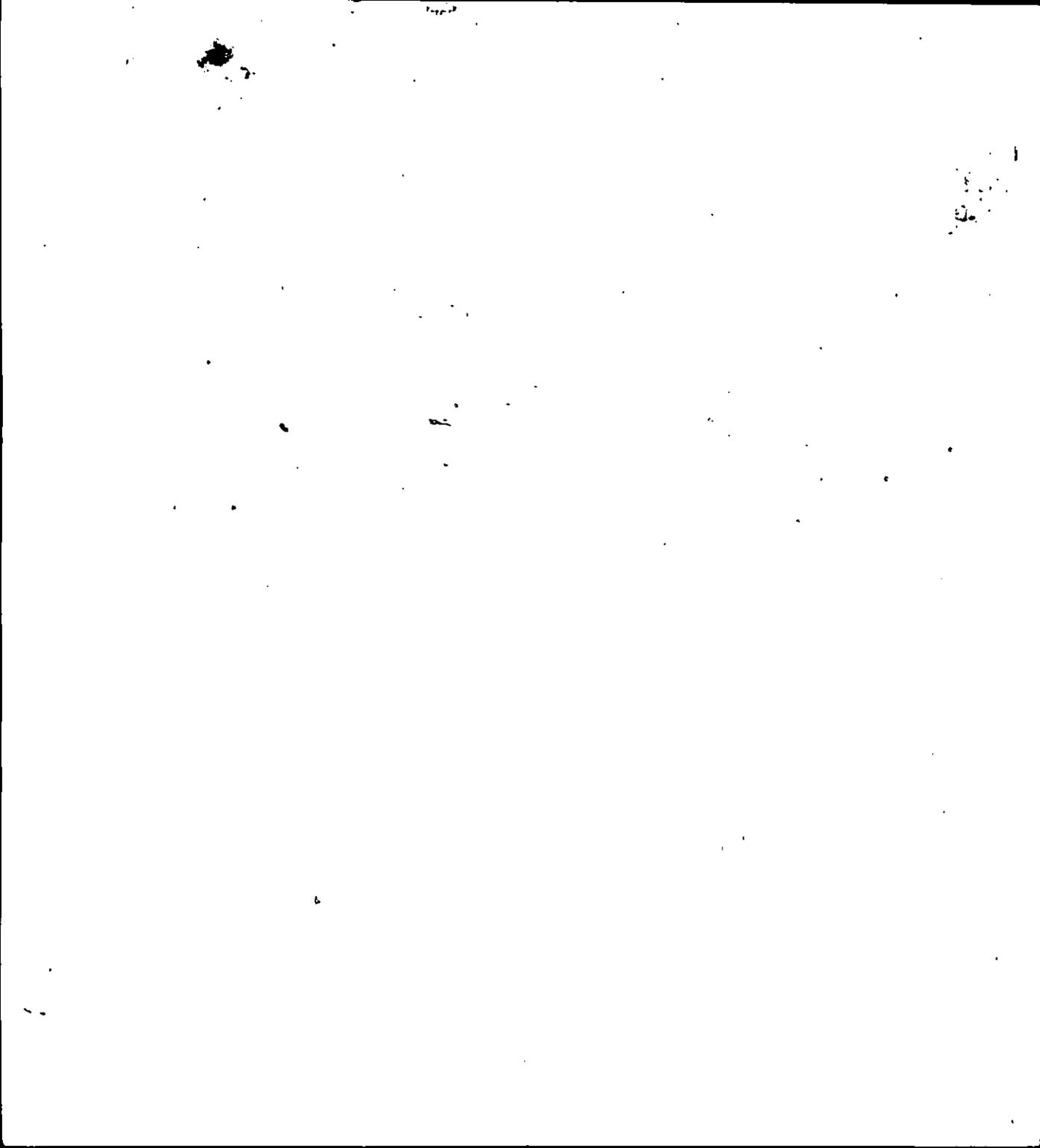
\*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Stewartsville, Mo. DATE OF BURIAL Mar. 6 1931

20. UNDERTAKER Fleeman Funeral Home Inc. ADDRESS St. Joseph Mo.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

21 1931



**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

ALL INFORMATION CALLED  
FOR MUST BE WRITTEN ON  
THIS SUPPLEMENTARY.

**1. PLACE OF DEATH**

County Duch

Registration District No. 83

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 1001

Registered No. 240

City St. Joseph (No. \_\_\_\_\_)

St. \_\_\_\_\_ Ward \_\_\_\_\_

**2. FULL NAME** Lillian D. Gregory

(a) Residence, No. \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) m

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF \_\_\_\_\_

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) \_\_\_\_\_

7. AGE YEARS MONTHS DAYS If LESS than 1 day, \_\_\_\_\_ hrs. or \_\_\_\_\_ min.

OCCUPATION  
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. \_\_\_\_\_  
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. \_\_\_\_\_  
10. Date deceased last worked at this occupation (month and year) \_\_\_\_\_ 11. Total time (years) spent in this occupation \_\_\_\_\_

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

FATHER 13. NAME \_\_\_\_\_

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

MOTHER 15. MAIDEN NAME \_\_\_\_\_

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) \_\_\_\_\_

17. INFORMANT (ADDRESS) \_\_\_\_\_

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19 \_\_\_\_\_

19. UNDERTAKER (ADDRESS) \_\_\_\_\_

20. FILED 5-6 1931 John R. Bende Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 4, 1931

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said

to have occurred on the date stated above, at \_\_\_\_\_ m.

The principal cause of death and related causes of importance were as follows:

Hypertension with metastasis to vena cava & retroperitoneal lymph glands. Primary adrenal gland. Date of onset \_\_\_\_\_  
Other contributory causes of importance: Shock - surgical

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? \_\_\_\_\_ Date of injury \_\_\_\_\_, 19\_\_\_\_

Where did injury occur? \_\_\_\_\_ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury \_\_\_\_\_

Nature of injury \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) \_\_\_\_\_, M. D.

(Address) \_\_\_\_\_

SUPPLEMENTARY

N. B.—Every item of information should be carefully supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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