

JAN 18 1934

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

Do not use this space.

1. PLACE OF DEATH

County

Township

City

Registration District No.

Primary Registration District No.

No.

File No.

Registered No.

St.

Ward)

2. FULL NAME

(a) Residence, No.

(Usual place of abode)

No.

Ward.

(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

MEDICAL CERTIFICATE OF DEATH

3. SEX *Male* 4. COLOR OR RACE *White* 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED *Married*

21. DATE OF DEATH (MONTH, DAY, AND YEAR) *12/7 1934*

5A. IF MARRIED, WIDOWED, OR DIVORCED, HUSBAND OF (OR) WIFE OF *Sadie F. Gray*

22. I HEREBY CERTIFY, That I attended deceased from *Jan 1932* to *12/7 1934*

I last saw him alive on *12/17 1934* Death is said

to have occurred on the date stated above, at *8:30 P.m.*

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) *April 28 - 1871*

7. AGE YEARS *63* MONTHS *7* DAYS *9* If LESS than 1 day, hrs. or min.

Date of onset

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. *Contractor*

Endocarditis, Chronic *Chronic*

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. *Saving*

93 P

112

920

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

Other contributory causes of importance: *Bronchial asthma* *July 1934*

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

13. NAME *Robert Gray*

Name of operation Date of

(What test confirmed diagnosis? Was there an autopsy?) *Chronic symptoms* *no*

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

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.

15. MAIDEN NAME *Susan Sadie*

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Ireland*

17. INFORMANT (ADDRESS) *Mrs. Sadie F. Gray*

18. BURIAL, CREMATION, OR REMOVAL PLACE DATE

19. UNDERTAKER (ADDRESS) *J. O'Donnell*

20. FILED *12/9 1934* *M. M. Crowe* Registrar

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.

279
15
15
15

