

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

4385
Do not use this space.

1. PLACE OF DEATH
 (a) County Hellman Registration District No. 851
 (b) Township Jackson Primary Registration District No. 6124 Registered No. _____
 (c) City Boonville (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME EMMA MARIETTA GRAY 600
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

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

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF SAMUEL GRAY

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) JUN 25, 1850

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 87 6 29

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSE WIFE
 9. Industry or business in which work was done, as 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) TORONTO CANADA

FATHER 13. NAME ENACH KELLY
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TORONTO CANADA

MOTHER 15. MAIDEN NAME LUCINDA COMBER
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) TORONTO CANADA

17. INFORMANT (ADDRESS) BERTIE DRURY BOONVILLE, MO.

18. BURIAL, CREMATION, OR REMOVAL PLACE Hillside Cemetery DATE Jan 29, 1938

19. FUNERAL DIRECTOR (ADDRESS) Wagon & Son Milan, Mo.

20. FILED Feb 10, 1938 Alto Hagan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH (MONTH, DAY, AND YEAR) JAN 27, 1938

I HEREBY CERTIFY, That I attended deceased from 1-17-38, 1938, to 1-27-38, 1938
 I last saw him alive on 1-27-38, 1938. Death is said to have occurred on the date stated above, at 5:00 P.M.
 The principal cause of death and related causes of importance were as follows:
Septicemic Toxæmia
Fractured Hip
 Date of onset 1-25-38

Other contributory causes of importance: _____

Name of operation _____ Date of _____
 What test confirmed diagnosis? Medical Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? acc Date of injury 1-19-38
 Where did injury occur? Home Boonville, Mo.
 (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
Fell from bed

Manner of injury _____
 Nature of injury Fracture of femur, neck

24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) T. E. Shury, M. D.
 (Address) Boonville City Mo.

186a

RECEIVED

FEB 28 1938

BUREAU OF VITAL STATISTICS
MO. STATE BOARD OF HEALTH

STATEMENT BY LICENSED EMBALMER

I, Russell C. Riggins....., Licensed Embalmer No. 3792

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me

..... L. E.

No. or by Registered Apprentice No.

working under my personal supervision.

Signed Russell C. Riggins
..... Licensed Embalmer No. 3792

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

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

4385
Do not use this space.

1. PLACE OF DEATH

(a) County Sullivan Registration District No. 857
 (b) Township Jackson Primary Registration District No. 6124 Registered No. _____
 (c) City _____ (d) Street No. _____ St. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Emma Marietta Gray

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED wid
 (write the word)

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.
87 6 29

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as 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. FUNERAL DIRECTOR (ADDRESS)

20. FILED 19__

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 27 1938

22. I HEREBY CERTIFY, That I attended deceased from

19__ 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:

Hypostatic pneumonia
1860 18
fractured hip
 Date of onset

Other contributory causes of importance:

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? suicide Date of injury 1-19 1938

Where did injury occur? home - Baynton Mo

(Specify city & town, county, and State)

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

Fall from bed

Manner of injury _____

Nature of injury fracture of femur neck

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

If so, specify _____

(Signed) H. E. Schwan M. D. 0

(Address) Green City Mo

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

S-4385-

1938