

No. 2  
5-43  
5-17-39  
I X36671

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 29360

FILED SEP 18 1944  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 7678

1. PLACE OF DEATH:  
(a) County St. Louis  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1052 No 6th St.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 1 (Specify whether  
In this community years, months or days) (Specify whether

2. USUAL RESIDENCE OF DECEASED:  
(a) State Mo (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1052 No 6th St.  
(If rural, give location)  
(e) Citizen of foreign country? U (Yes or No)  
If yes, name country U

3. (a) PRINT FULL NAME William Gray  
3. (b) If veteran, name war U 3. (c) Social Security No. U

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced U  
6. (b) Name of husband or wife U 6. (c) Age of husband or wife if alive U years  
7. Birth date of deceased abt 1878  
(Month) (Day) (Year)

8. AGE: Years abt 66 Months Days If less than one day hr. min.

9. Birthplace U Indiana  
(City, town, or county) (State or foreign country)

10. Usual occupation retired

11. Industry or business retired

12. Name William Gray

13. Birthplace U Indiana  
(City, town, or county) (State or foreign country)

14. Maiden name U

15. Birthplace U  
(City, town, or county) (State or foreign country)

16. (a) Informant James J. Fitzgibbon  
(b) Address 1300 Clark

17. (a) (Burial, cremation, or removal) Washington D.C. (b) Date thereof 8/14/44  
(Month) (Day) (Year)

(c) Place: burial or cremation Washington D.C.

18. (a) Signature of funeral director W. R. Kutz  
(b) Address 3500 Rutger St

19. (a) SEP 6 1944 (b) J. J. Medel  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 30 year 1944 hour 6 minutes 30 A. M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;

that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Multiple lung abscesses and abscess in liver

Due to Non-tuberculous abscesses

Other conditions (Include pregnancy within 3 months of death) U

Major findings: Of operations 125

Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) (c) Means of injury \_\_\_\_\_

23. Signature Alfred W. Perry (M. D. or other) U  
Address Appt. Room Date signed 8/14/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

844

7678

---

---

**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.....  
....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

**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 this body is not embalmed, fact should be so stated above.**