. S. No. 2
0M—5-43
v. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

# STANDARD CERTIFICATE OF DEATH

FILED AUG 11 1945

State File No. 21965

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 6940

**1. PLACE OF DEATH:**

(a) County

(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
Homer G. Phillips Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days)

In this community Unknown

**2. USUAL RESIDENCE OF DECEASED:**

(a) State Missouri (b) County 000

(c) City or town St. Louis, 17 11
(If outside city or town limits, write "RURAL")

(d) Street No. 4340 W. Bell 0
(If rural, give location) 1

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ross Gray

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Male d

5. Color or race Negro

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive years

7. Birth date of deceased Unknown (Month) (Day) (Year)

8. AGE: Years About 80 | Months — | Days — | If less than one day hr. min.

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

10. Usual occupation Chauffeur

11. Industry or business

MOTHER FATHER

12. Name Unknown 9

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

14. Maiden name Unknown 9

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

16. (a) Informant Josie Lee

(b) Address 4443 West Belle Pl

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8-6-45 (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood Cemt.

18. (a) Signature of funeral director Russell Und Co

(b) Address 2732 Pine St.

19. (a) AUG 7 1945 (Date received local registrar) J. F. Bredeck (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month August day 4, year 1945 hour 3 minute 55 A. M.

21. I hereby certify that I attended the deceased from July 24, 1945 to August 4, 1945 that I last saw him alive on August 4, 1945 and that death occurred on the date and hour stated above.

| Immediate cause of death | Duration |
|---|---|
| Prostatic Hypertrophy | Unk. |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death) 137 | |

Major findings:
Of operations

Of autopsy

PHYSICIAN — Underline the cause to which death should be charged statistically.

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature B. F. Murphy (M.D.)

Address 2601 N. Whitelock Date signed 8/4/45

(Licensed Embalmer's Statement on Reverse Side)

6940

6940

**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 Joel Russell

Licensed Embalmer No. 4112

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.**