

FILED APR 2 1947

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **86**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Marksville**
(c) Name of hospital or institution: **Drum - Smith Hosp**
(d) Length of stay: **1 night**
In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Scott**
(c) City or town **Reed**
(d) Street No. **West of Ark**
(e) Citizen of foreign country? _____
If yes, name country _____

3. (a) PRINT FULL NAME

William F. Gray

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Divorced**

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased **Nov 28 1896**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	90	3	14	hr. min.

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

10. Usual occupation **Farming**

11. Industry or business _____

12. Name **Geo. E. Gray**

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

14. Maiden name **Mary Ann Jones**

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

16. (a) Informant **Frank Gray**

(b) Address **W. parsona rd**

17. (a) **Buried** (b) Date thereof **Mar 14 / 47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hickory Grove**

18. (a) Signature of funeral director **Walter Lambert**

(b) Address **Memphis TN**

19. (a) **3-24-47** (b) **Walter Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **March** day **12** year **1947** hour **4** minute **30 PM**

21. I hereby certify that I attended the deceased from **April 11**, 1947, to **March 12**, 1947, that I last saw him alive on **April 26**, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary atherosclerosis with valvular heart disease**

Due to **hypertension and chronic interstitial nephritis**

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

Major findings: Of operations _____ Of autopsy **1313**

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 **Walter Lambert** (Physician or other)

Address **Marksville Mo** Date signed **3-14-47**

Duration

15 min

Year

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

RECEIVED
District Health Officer No. 10
District File Number *4272014*
Date Filed *APR 1 1947*

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..... *Fred Schultz*

Licensed Embalmer No..... *4258*

P. O. Address..... *Murphy*

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.