

No. 2  
1-5-43  
5-17-39  
KX36671

FILED AUG 16 1947

Registration District No. 517

Primary Registration District No. 6076

1. PLACE OF DEATH:

RURAL

(a) County St. Louis County  
(b) City or town St. Louis County  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
IN-Route to Hospital 13  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 15 years (Specify whether years, months or days)

3. (a) PRINT FULL NAME

Augustus Gray Sr.

3. (b) If veteran,

name war None

3. (c) Social Security

No. None

4. Sex Male 5. Color or race Negro

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

6. (b) Name of husband or wife

6. (c) Age of husband or wife if alive None years

7. Birth date of deceased January 9 1930  
(Month) (Day) (Year)

8. AGE: Years 17 Months 6 Days 28

If less than one day hr. min.

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

(State or foreign country)

10. Usual occupation laborer

11. Industry or business

12. Name Augustus Gray Sr.

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

14. Maiden name Notie Jones

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

16. (a) Informant Augustus Gray

(b) Address 3431 Lawton St.

17. (a) Burial (b) Date thereof 8-9-47  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Dayd Brothers

(b) Address 3704 Finney Ave.

19. (a) 8-8-47 (b) Beulah Slapnick  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3851 Cook  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 8 day 6  
year 47 hour minute M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw h\_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death carbon monoxide poisoning, overcome by gas from a well when assisting a fellow workman

Due to 178  
Other conditions 11  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. If death was due to external causes, fill in the following:  
(a) Accident, suicide, or homicide (specify) Accident  
(b) Date of occurrence August 6, 1947  
(c) Where did injury occur? St. Louis County, Mo.  
(City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?  
On farm

(Specify type of place) Asphyxia  
While at work? (c) Means of injury \_\_\_\_\_  
23. Signature Emmett J. Willmann (M. D. or other) Coroner 3  
Address Clayton, Mo. Date signed 8/7/47

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

MOTHER FATHER

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**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. *4344*

P. O. Address..... *St Louis 13 Mo*

**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.**

Registration District No. 317 Primary Registration District No. 6076

1. PLACE OF DEATH:

(a) County ST. LOUIS rural  
(b) City or town DOE at county hospital  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Clayton mo  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Augustus Murphy  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month Aug year 1947 hour \_\_\_\_\_ minute \_\_\_\_\_ M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_  
that I last saw him alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.  
Immediate cause of death \_\_\_\_\_

4. Sex M 5. Color or race B 6. (a) Single, widowed, married, divorced S  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan (Month) 17 (Day) \_\_\_\_\_ (Year) \_\_\_\_\_  
8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_  
(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

Duration \_\_\_\_\_  
Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

PHYSICIAN \_\_\_\_\_  
Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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?  
While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_  
23. Signature \_\_\_\_\_ (M. D. or other)  
Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY 6

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

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