WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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

PLACE OF DEATH

County Scott

Township Kelso
or
Village Rockview
or
City _____ (NO. _____ St.; _____ Ward)

Registration District No. 816 File No. 26591

Primary Registration District No. 6065 Registered No. 34

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Vanndes, Eugene, Gray.

PERSONAL AND STATISTICAL PARTICULARS

SEX Male | COLOR OR RACE White | SINGLE MARRIED WIDOWED OR DIVORCED (Write the word) Single

DATE OF BIRTH Oct. (Month) 19 (Day) 1912 (Year)

AGE 2 yrs. 9 mos. 25 ds. | If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) "

BIRTHPLACE (City or town, State or foreign country) Dexter Mo.

PARENTS
NAME OF FATHER James. L. Gray.
BIRTHPLACE OF FATHER (City or town, State or foreign country) White Co. Ill.
MAIDEN NAME OF MOTHER Edna. Grace. Nash.
BIRTHPLACE OF MOTHER (City or town, State or foreign country) Ind.

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fd. Gray

(ADDRESS) Rockview, Mo

Filed Aug. 15, 1915 G A Sample REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH Aug. 14 (Month) (Day) 1915 (Year)

I HEREBY CERTIFY, that I attended deceased from One visit Aug. 14, 1915, to Aug. 14, 1915, that I last saw him alive on Aug. 14, 1915, and that death occurred, on the date stated above, at 6:55 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Malarial Fever,

38 04

(Duration) ___ yrs. ___ mos. 3 ds.

Contributory (SECONDARY) _____

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) W. T. Daughtrey M. D.

Aug. 15, 1915 (Address) Chaffee, Mo.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL Rockview Mo | DATE OF BURIAL 8/15 1915

UNDERTAKER H. T. Stubbs | ADDRESS Chaffee Mo

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

PLACE OF DEATH

County .....

Township ..... or Village ..... or City ..... (NO. .... St.; ..... Ward)

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

SEX | COLOR OR RACE | SINGLE MARRIED WIDOWED OR DIVORCED (*Write* the word)

DATE OF BIRTH ..... (Month) ..... (Day) ....., 1..... (Year)

AGE ..... yrs. ..... mos. ..... ds. | If LESS than 1 day, ... hrs. or ..... min.?

OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

BIRTHPLACE (City or town, State or foreign country) .....

PARENTS
- NAME OF FATHER .....
- BIRTHPLACE OF FATHER (City or town, State or foreign country) .....
- MAIDEN NAME OF MOTHER .....
- BIRTHPLACE OF MOTHER (City or town, State or foreign country) .....

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(ADDRESS) .....

Filed ...., 191....., ...
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH ..... (Month) ..... (Day), 191..... (Year)

I HEREBY CERTIFY that I attended deceased from ....., 191....., to ....., 191....., that I last saw h..... alive on ....., 191....., and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

....., 191..... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....., 191.....

UNDERTAKER | ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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