

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

Do not use this space.

27232

1. PLACE OF DEATH

County Jackson Registration District No. 399

Township Kaw Primary Registration District No. 3900

City Kansas City, Mo. 1817 East 43rd, St. _____ Ward)

File No. _____

Registered No. 3491

St. _____ Ward)

2. FULL NAME Mrs. Emma E. Gray

(a) Residence. No. 1817 east 43rd, St. 15 Ward. _____

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED OR DIVORCED widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Jan, 14, 1854

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
<u>73</u>	<u>7</u>	<u>27</u>		

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) Lexington,
(STATE OR COUNTRY) Missouri.

PARENTS

10. NAME OF FATHER Joseph Trotter

11. BIRTHPLACE OF FATHER (CITY OR TOWN) _____
(STATE OR COUNTRY) North Carolina

12. MAIDEN NAME OF MOTHER Harriet Foster

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____
(STATE OR COUNTRY) do not know

14. INFORMANT Leroy P. Gray
(Address) 1817 E. 43rd Kansas City

15. FILED 9/12 1927 M. M. Brown REGISTRAR
Asst

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 9-11-1927

17. I HEREBY CERTIFY, That I attended deceased from 8-10-1927, to 9-11-1927, 1927 that I last saw h. s. alive on 9-10-1927, and that death occurred, on the date stated above, at 2:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Myocarditis
930
97
(duration) _____ yrs. _____ mos. _____ ds.
CONTRIBUTORY Arterio Sclerosis
(SECONDARY) several
(duration) _____ yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED? 900 B
IF NOT AT PLACE OF DEATH _____

9 DID OPERATION PRECEDE DEATH? X DATE OF _____

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? General Symptoms

(Signed) A. M. Harrison, M.D.

9-11, 1927 (Address) 3425 Leekham Rd

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Lexington, Mo. DATE OF BURIAL 9/13/27

20. UMBERTAKER The Freeman Mortuary ADDRESS 3146 Main

A. M. Harrison, M.D.

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.

PERMANENT RECORD

