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

Do not use this space.

29248 B

1. PLACE OF DEATH
County: Saline
Registration District No.: 796
File No.:
Township:
Primary Registration District No.: 3038
Registered No.: 123
City: Marshall (No. ..... St. ..... Ward)

2. FULL NAME: Annie McGray

(a) Residence. No. ..... St., ... Ward. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... 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: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word): Widow

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Aug 4th 1865

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
62	1	22	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN): Saline Co.
(STATE OR COUNTRY): Mo

PARENTS

10. NAME OF FATHER: James Collier
11. BIRTHPLACE OF FATHER (CITY OR TOWN): Dont Know
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): Dont Know
(STATE OR COUNTRY)

14. INFORMANT: Elizabeth Gentlefield
(Address): Marshall Mo

15. FILED 10/1 1927 D. F. Manning REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 9-26 1927

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at ..... m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
unknown probably some
mitral heart trouble
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): 90 N
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
8 DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....
(Signed) B. M. Scotts Coroner, M. D
10/1, 1927 (Address) Marshall Mo

*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: Fairview Cemetery
DATE OF BURIAL: 10-2 1927

20. UNDERTAKER: R Robbins
ADDRESS: Marshall Mo

NOV 20 1927

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.