1928

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

Do not use this space.

36544

File No. .....

Registered No. 767

1. PLACE OF DEATH

County Greene — Registration District No. 318

Township ..... — Primary Registration District No. 2001

City Springfield (No. 850 S. Robberson St. Ward)

2. FULL NAME Herbert Stanley Gray

(a) Residence. No. 850 S. Robberson St. Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 8 ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: wm

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): child

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR): Nov. 6-1926

7. AGE: Years 1 | Months 1 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

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

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

PARENTS

10. NAME OF FATHER: James Brawer

11. BIRTHPLACE OF FATHER (CITY OR TOWN):
(STATE OR COUNTRY): Mo.

12. MAIDEN NAME OF MOTHER: Florine Gray

13. BIRTHPLACE OF MOTHER (CITY OR TOWN):
(STATE OR COUNTRY): Mo.

14. INFORMANT: Florine Gray
(Address): 850 S. Robberson

15. FILED 12/16 1927 O. C. Forst M.D.
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR): 12-14-1927

17. I HEREBY CERTIFY, That I attended deceased from 12-9-1927, to 12-9-1927, that I last saw h. ~~living~~ alive on 12-9-1927, and that death occurred, on the date stated above, at 7:45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pneumonia Bronchi

107 A

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY)

(duration) ..... yrs. ..... mos. ..... ds.

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

DID AN OPERATION PRECEDE DEATH? No DATE OF

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? No

(Signed) Bertram Mott M. D.

12/14 1927 (Address) Springfield 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: Pearson Cemetery — DATE OF BURIAL 12-16 1927

20. UNDERTAKER: W. E. Farrar — ADDRESS Mo.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH properly classified. Exact statement of OCCUPATION is very important.

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

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Greene — Registration District No. 318 — File No.
Township — Primary Registration District No. 2001 — Registered No. 767
City Springfield (No. ..... St. ..... Ward)

2. FULL NAME Herbert Stanley Gray
(a) Residence. No. ..... St., ... Ward. ..... (If nonresident give city or town and State)
(Usual place of abode)
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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
M	B	S

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

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

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. FILED 12/16, 1927 OC Horst MSE
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 12-14 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:
Pneumonia Broncho
Primary
(duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (SECONDARY)
(duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH?
DID AN OPERATION PRECEDE DEATH? ..... DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) ....., M. D
, 19 (Address)

*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	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

N. B.—Every item of information should be carefully supplied. USE ... plain terms, so that it may be proper. AGE should be stated ... CAUSE OF DEATH in plain terms ... properly classified. Exact statement

5-36594