

FEB 21 1928

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

Do not use this space.

770

1. PLACE OF DEATH

County Linn

Registration District No. 318

File No. \_\_\_\_\_

Township \_\_\_\_\_

Primary Registration District No. 2001

Registered No. 38

City Springfield (No. 513)

St. \_\_\_\_\_ Ward \_\_\_\_\_

State \_\_\_\_\_

2. FULL NAME

(a) Residence. No. 513 St. \_\_\_\_\_ Ward \_\_\_\_\_

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 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 W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word) widow

6. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Thos. J. Gray

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 14 1844

7. AGE YEARS 83 MONTHS 3 DAYS 1 If LESS than 1 day, \_\_\_\_ hrs. or \_\_\_\_ min.

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife  
(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) Ohio

10. NAME OF FATHER Jos. Mason

11. BIRTHPLACE OF FATHER (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) Ohio

12. MAIDEN NAME OF MOTHER Mrs. Mason

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) \_\_\_\_\_

(STATE OR COUNTRY) Ohio

14. INFORMANT J. C. Gray

(Address) # 9

15. FILED 1/17 1928

O'Connor REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1-15-28

17. I HEREBY CERTIFY That I attended deceased from 1/9 to 1-16-28 that I last saw him alive on 1-15-28 and that death occurred, on the date stated above, at 2:50 P.M.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:

Heber. Pneumonia  
108 (duration) yrs. mos. ds.  
CONTRIBUTORY (SECONDARY) 10/10 (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: \_\_\_\_\_

(Signed) Dr. C. C. Gray M. D.

116 (Address) Springfield Mo.

\*State the DISEASE CAUSING DEATH, if by 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 Maple Crest CEMETERY

DATE OF BURIAL 1-17-28

20. UNDERTAKER W. J. Harve

ADDRESS Market

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.

