

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

Do not use this space.

19930

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 11003
 City St. Louis (No. Deaconess Hosp.) St. _____ Ward _____

File No. _____
 Registered No. 5555

2. FULL NAME

Elizabeth R. Gray
 (a) Residence. No. 5145 Perry Ave. St. 6 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. da. How long in U.S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) March 30 1879

7. AGE	YEARS	MONTHS	DAY	IF LESS than 1 day, hrs. or min.
	50	1	17	

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) St. Louis
 (STATE OR COUNTRY) Missouri

10. NAME OF FATHER George Reynolds

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

12. MAIDEN NAME OF MOTHER W. M. M. M.
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Pomeroy
 (STATE OR COUNTRY) Kentucky

14. INFORMANT Mr. Frank Gray
 (Address) 5145 Perry Ave.

15. FILED MAY 20 1929 May C. Starkey
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 17 1929

17. I HEREBY CERTIFY That I attended deceased May 13, 1929 to May 17, 1929 that I last saw her alive on May 17, 1929, and that death occurred, on the date stated above, at _____

THE CAUSE OF DEATH WAS AS FOLLOWS:
Pneumonia (Lobar)
Chor. Myocarditis
105
100
930 / 0 / 0 (duration) yrs. mos. da.
 CONTRIBUTORY (SECONDARY) Myocardial degeneration (duration) yrs. mos. da.
Operation for Gall stones

18. WHERE WAS DISEASE CONTRACTED _____
 IF NOT AT PLACE OF DEATH, at place of death
Gall Bladder OP. DATE OF OPERATION May 14 1929
 DID AN OPERATION PRECEDE DEATH? no

WAS THERE AN AUTOPSY? _____
 WHAT TEST CONFIRMED DIAGNOSIS? clinical
 (Signed) M. N. Foster, M. D.
517 / 1929 (Address) 4139 Chouteau

*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 Memorial Park Cem DATE OF BURIAL 5-20 1929

20. UNDERTAKER Geo. L. Pleitsch ADDRESS 5966 Easton Ave.

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.

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