

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

Do not use this space.

14279

File No. _____
Registered No. **3618**
St. _____ Ward _____

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City _____ (No. *City Hospital #2*)

2. FULL NAME *Emma Kingston*

(a) Residence. No. *2607 Thomas St.* *21* Ward.
(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. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *Female* 4. COLOR OR RACE *Negro* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *Widowed*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Nov. 25-1879*

7. AGE	YEARS	MONTHS	DAY	If LESS than 1 day, _____ hrs. or _____ min.
<i>45</i>	<i>4</i>	<i>14</i>		

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) _____ (STATE OR COUNTRY) *Kentucky*

10. NAME OF FATHER *Calvin M. Gray*

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

12. MAIDEN NAME OF MOTHER *Ruthie Keathers*

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) _____ (STATE OR COUNTRY) *unknown*

14. INFORMANT *Chandler Stoner*
(Address) *2607 Thomas St*

15. FILED _____ 19____
Wm C. Storker REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *April 9, 1930*

17. *No physician in attendance*
I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____, and that I last saw him _____ alive on _____, 19____, and that death occurred, on the date stated above, at _____ m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Cerebral Apoplexy
82A (Chronic Traumatic)
(duration) _____ yrs. mos. ds.

CONTRIBUTORY (SECONDARY) _____ (duration) _____ yrs. mos. ds.

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

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____

20. WAS THERE AN AUTOPSY? *Yes*

WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) *John Herley* M.D.
111 1/2 St (Address) *Dr. J. P. Coover*

*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 *Burdstown Ky* DATE OF BURIAL *4/11 30*

20. UNDERTAKER *Russell and Co* ADDRESS *2732 Pine St.*

WHITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

