JUN 27 1930

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

Do not use this space.

16923

1. PLACE OF DEATH, County Perry; Township Cape Miscellaneous; City ..... (No. ....., ..., St. ....., Ward)

Registration District No. 651
Primary Registration District No. 4388

File No. .....
Registered No. 50

2. FULL NAME Wesley Gray

(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.

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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Blk
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

5a. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: Lizzie Gray

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

7. AGE: about 58 Years; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

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

9. BIRTHPLACE (CITY OR TOWN): West Point
(STATE OR COUNTRY): Miss

PARENTS

10. NAME OF FATHER: Will Gray
11. BIRTHPLACE OF FATHER (CITY OR TOWN): West Point
(STATE OR COUNTRY): Miss
12. MAIDEN NAME OF MOTHER: Olivia Bonner
13. BIRTHPLACE OF MOTHER (CITY OR TOWN): West Point
(STATE OR COUNTRY): Miss

14. INFORMANT: Lizzie Gray
(Address): Cape Girardeau, Mo.

15. FILED May 8, 1930. Ada Martin, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

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16. DATE OF DEATH (MONTH, DAY AND YEAR): May 7th 1930

17. I HEREBY CERTIFY, That I attended deceased from June, 1927, to May 6, 1930, that I last saw him alive on May 6, 1930, and that death occurred, on the date stated above, at 11:45 P.M.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Chronic tuberculosis
231
232
(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY): Hemorrage of lungs
(duration) ..... yrs. ..... mos. 1 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) Jacob M. Lockfield, M. D.
May 7, 1930 (Address) Cape Girardeau, 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: Mason Cemetery
DATE OF BURIAL: 5-8 1930

20. UNDERTAKER: W. M. Fardrick
ADDRESS: Grile