

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

Do not use this space.

1. PLACE OF DEATH

County.....
Township.....
City..... (No. *St. Mary*)

Registration District No. **791**
Primary Registration District No. **1003**
Superior

File No. **24361**
Registered No. **6496**
St. Ward)

2. FULL NAME

Mathews Grey
(a) Residence No. *2311 Polk* St., *1* 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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *col* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) *married*

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *aug 18 79*

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
<i>About 71</i>				

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work *Labor*
(b) General nature of industry, business, or establishment in which employed (or employer) *scaleade*
(c) Name of employer *Gas Co*

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) *Columbia Tenn*

10. NAME OF FATHER *Joe Grey*

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

12. MAIDEN NAME OF MOTHER *unknown*

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

14. INFORMANT *Marah Grey*
(Address) *2311 Polk*

15. FILED *11* *6* 19*30* *Mar C Stork* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *July 2, 1930*

17. *No Physician in attendance*
I HEREBY CERTIFY, That I attended deceased from

that I last saw him alive on 19..... and that death occurred, on the date stated above, at *8:00 A. M.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:

924 Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) *90 W*

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH.....

8 DID AN OPERATION PRECEDE DEATH? DATE OF.....

WAS THERE AN AUTOPSY? *yes*

WHAT TEST CONFIRMED DIAGNOSIS? *John Fisher*

(Signed) *John Fisher* M. D.

7/3, 1930 (Address) *Deputy Coroner*

*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 *Father Dickerson* DATE OF BURIAL *7-7 1930*

20. UNDERTAKER *Wasservandlar* ADDRESS *2769 Chouteau*

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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