

OCT 28 1930

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

Do not use this space.

29329

1. PLACE OF DEATH

County *Cape Girardeau*

Registration District No. *125*

Township *1*

Primary Registration District No. *3009*

City *Cape Girardeau*

(No. *S. G. No. Hospital*)

File No. _____

Registered No. *512*

St. _____ Ward) _____

2. FULL NAME

Emma Aline Gray

(a) Residence. No. *5798 Kingsbury Place* St. _____ Ward. _____

(Usual place of abode) ~~_____~~ (If non-resident, 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

F

4. COLOR OR RACE

W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)

Married

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

R B. Gray

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

Dec 20, 1864

7. AGE

YEARS

MONTHS

DAYS

IF LESS than 1 day, _____ hrs. or _____ min.

65

9

2

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)

Groesbeek

10. NAME OF FATHER

Harold H. Davis

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY)

North Carolina

12. MAIDEN NAME OF MOTHER

Artie Workmann

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY)

14. INFORMANT

R B. Davis
(Address) *5798 Kingsbury Place - St. Louis*

15. FILED

9/23 1930 *W. Kaempfer*
REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *9 - 22 1930*

17. I HEREBY CERTIFY, That I attended deceased from *Sept 20*, 19*30*, to *Sept 22*, 19*30*

that I last saw her alive on *Sept 22*, 19*30*, and that death occurred, on the date stated above, at *2:45 P.* m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Acute pneumonia
1868
1948 (duration) yrs. *6* mos. da.

CONTRIBUTORY (SECONDARY) *fall down stairs*
fracture of skull (duration) yrs. mos. *1* da.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH: _____

0 DID AN OPERATION PRECEDE DEATH? *no* DATE OF _____

WAS THERE AN AUTOPSY? *no*

WHAT TEST CONFIRMED DIAGNOSIS? *Lab. exam*

(Signed) *J. W. Berry*, M. D.

, 19 (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

DATE OF BURIAL

Municipal Cemetery - St. Louis

9-25 1930

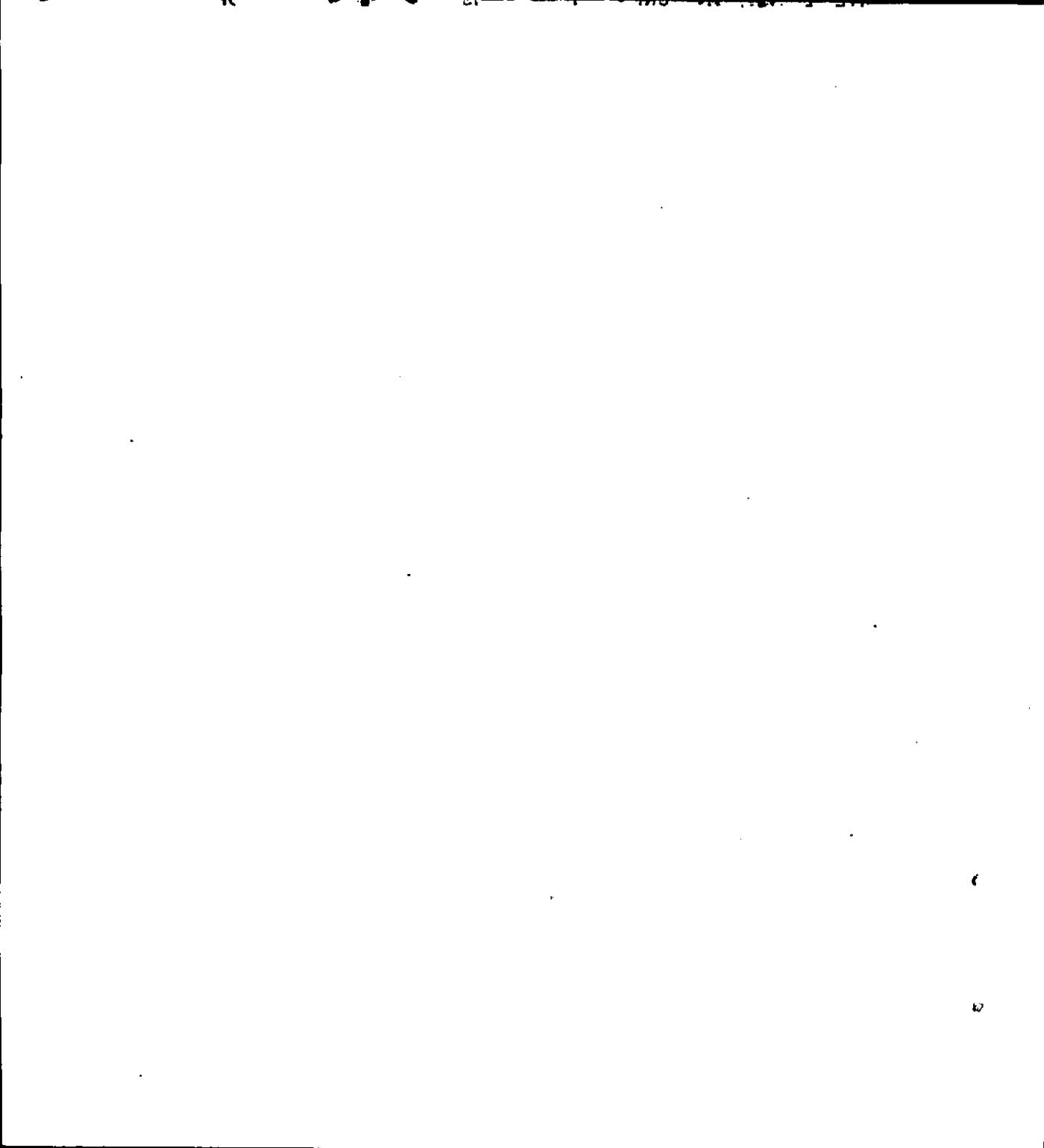
20. UNDERTAKER

ADDRESS

McConis Farm Seed Co.

Jackson Mo

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.



S-29329