OCT 31 1930

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

Do not use this space.

Dr Kane

30723

1. PLACE OF DEATH

County Pettis — Registration District No. 668 — File No.

Township — Primary Registration District No. 3432 — Registered No. 229

City Sedalia (No. 1815 E 6th St. Ward)

2. FULL NAME Emmola Hazel Gray

(a) Residence. No. 1815 E 6th St., Ward. (If nonresident, give city or town and State)
(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: 7

4. COLOR OR RACE: W

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 9 1910

7. AGE

YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
20	1	27	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(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) Mo

PARENTS

10. NAME OF FATHER H T Gray

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

12. MAIDEN NAME OF MOTHER Theresa Owens

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

14. INFORMANT H T Gray
(Address) Sedalia Mo

15. FILED 4/9, 1930 J. G. Love REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Sept 6 1930

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1929, to Sept. 6, 1930 that I last saw her alive on Sept. 6, 1930, and that death occurred, on the date stated above, at 11:00 A.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Pulmonary Tuberculosis — (Acute pneumonia following severe hemorrhage)

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (SECONDARY) 31

(duration) yrs. mos. 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 Clinic & Laboratory

(Signed) Clifford C. Kane, M. D.

, 19 (Address) 301 S. Ohio, Sedalia 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: Crown Hill — DATE OF BURIAL: 9/8 1930

20. UNDERTAKER: Gillespie — ADDRESS: Sedalia

WRITE 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.