

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

Do not use this space.

33910

1. PLACE OF DEATH *City*
 County..... Registration District No. *198*
 Township..... Primary Registration District No. *3011*
 City, *Excelsior City, Mo.* (No. *Broadway hotel*)..... St. Ward)

2. FULL NAME *William J. Gray*
 (a) Residence. No. *930 Ivondale KCK* 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.

File No.
 Registered No. *127*..... Ward)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX *male* 4. COLOR OR RACE *white* 5. SINGLE, MARRIED, WIDOWED OR DIVORCED *widower*
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *Emma E.*
 6. DATE OF BIRTH (MONTH, DAY AND YEAR) *5/31/1854*
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.
77 4 4
 8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work..... *carpenter contractor*
 (b) General nature of industry, business, or establishment in which employed (or employer).....
 (c) Name of employer *self*

9. BIRTHPLACE (CITY OR TOWN).....
 (STATE OR COUNTRY) *Canada*

PARENTS
 10. NAME OF FATHER *unknown*
 11. BIRTHPLACE OF FATHER (CITY OR TOWN).....
 (STATE OR COUNTRY) *unknown*
 12. MAIDEN NAME OF MOTHER *unknown*
 13. BIRTHPLACE OF MOTHER (CITY OR TOWN).....
 (STATE OR COUNTRY) *unknown*

14. INFORMANT *Mr. W. Homer Cain*
 (Address) *2840 Parkwood KCK*

15. FILED *10/5/31* *W. Craven*
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

3 16. DATE OF DEATH (MONTH, DAY AND YEAR) *10/5* 19 *31*
 17. I HEREBY CERTIFY, That I attended deceased from
 19..... to 19.....
 that I last saw him alive on 19....., and that
 death occurred, on the date stated above, at G. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
chronic myo carditis
enlarged prostate
suppression of urine several
 (duration) yrs. mos. ds.
 CONTRIBUTORY (SECONDARY)
 (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 *Chemical*
 (Signed) *W. D. Craven* M. D.
10/5/31 (Address) *Excelsior Springs*

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSE, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
 19. PLACE OF BURIAL, CREMATION, OR REMOVAL *Highland Park Cem., K.C., Mo.* DATE OF BURIAL *10/5 1931*
 20. UNDERTAKER *Geo. H. Long* ADDRESS *K. C. K.*

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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