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

26826-1

26826-A

PLACE OF DEATH

County Montgomery — Registration District No. 591 — File No.

Township Prairie — Primary Registration District No. 5789 — Registered No.

City ..... (No. ..... St. ..... Ward)

FULL NAME James Monroe Gregory

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

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 4 mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: ale — 4. COLOR OR RACE: White — 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF ~~(or) WIFE~~ OF Henrietta Ellis Decd

DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 27-1856

AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
	75	8	12	

OCCUPATION OF DECEASED

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

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Pike County Mo 1

10. NAME OF FATHER Urah Gregory

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) Ky. 2

12. MAIDEN NAME OF MOTHER Margaret A Pharr

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) Pike Co Mo 1

INFORMANT (Address) Marvin Gregory

FILED Aug 10 1932 M M Davidson, REGISTRAR

2 MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug. 9, 1932 19

17. I HEREBY CERTIFY, That I attended deceased from July 18; 1932, 19..., to Aug. 9; 1932, 19..., that I last saw him alive on Aug. 6; 1932, 19..., and that death occurred, on the date stated above, at 1 45 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

131

82A 131

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) Cerebral Apoplexy

(duration) ..... yrs. ..... mos. 18 ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? no DATE OF ①

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? urinary

(Signed) A. Hirsch, M. D

Aug. 9, 1932 (Address) Middletown, 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. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Millcreek Creek Cemetery — DATE OF BURIAL: Aug 10 1932

20. UNDERTAKER: W. B. Elmore — ADDRESS: Bowling Green

V. S. NO. 2.

MARGIN RESERVED FOR BINDING

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.

V. S. No. 2.

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CERTIFICATE OF DEATH

1. PLACE OF DEATH

County..... Registration District No..... File No.....

Township..... Primary Registration District No..... Registered No. .....

City..... (No..... ..... St. ..... Wa

2. FULL NAME .....

(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.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

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

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

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

7. AGE — YEARS | MONTHS | DAYS | If LESS than 1 day, ...hrs. or .....min.

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)

PARENTS

10. NAME OF FATHER

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

12. MAIDEN NAME OF MOTHER

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

14. INFORMANT .....
(Address)

15. FILED....., 19..... .....
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 19

17. I HEREBY CERTIFY, That I attended deceased from ....,19....., to ....., 19 ..... that I last saw h..... alive on....., 19....., an death occurred, on the date stated above, at.....m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

.....

.....

.....

.....(duration).....yrs. .....mos.....

CONTRIBUTORY.....
(SECONDARY)

.....(duration).....yrs. .....mos.....

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?.....

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

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS?.....

(Signed).....

, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL HOMICIDAL. (See reverse side for additional space.)

19. PLACE OF BURIAL, CREMATION, OR REMOVAL | DATE OF BURIA

20. UNDERTAKER | ADDRESS