

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

Do not use this space.

3382

1. PLACE OF DEATH

County _____ Registration District No. _____
Township _____ Primary Registration District No. _____
City _____ (No. City Hospital, # 2) _____

File No. _____
Registered No. 281
St. _____ Ward) _____

2. FULL NAME

Joseph Gray
(a) Residence No. 2209 Euclid St., 21 Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE Negro 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) Unknown

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, hrs. or min.
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8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Labor - 2100

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. None

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jacksonville Florida

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Sarah Spencer 3209 Euclid

18. BURIAL, CREMATION, OR REMOVAL PLACE Greenwood DATE 1-9-33

19. UNDERTAKER (ADDRESS) C. W. Robert 2029 Euclid

20. FILED N-9 1933 19 Max C. Starkey Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 6, 1933

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____

I last saw him alive on _____, 19____. Death is said to have occurred on the date stated above, at 3:10 a.m.

The principal cause of death and related causes of importance were as follows:

Hypostatic Pneumonia following fracture of tibia & fibula (Rt.) - struck by Ford Sedan in St. Louis, on 1/3/33

Other contributory causes of importance: Removal Paralysis (Deceased was a Pedestrian) 200

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? Yes

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Yes Date of injury 1/3, 1933

Where did injury occur? St. Louis, Mo. (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place. Public Place

Manner of injury Struck by Automobile
Nature of injury fract. Rt. Tibia & Fibula

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____

(Signed) J. W. Spencer M.D.
(Address) 1933

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.

WRITE FAIRLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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