

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

Do not use this space.

31795

SEP 14 1934

1. PLACE OF DEATH

County North
Township Union
City Front City (No. _____)

Registration District No. 904
Primary Registration District No. 6215-

File No. _____
Registered No. _____
St. _____ Ward _____

2. FULL NAME

Caroline Gray

(a) Residence No. _____ St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug. 1, 1859

7. AGE YEARS MONTHS DAYS If LESS than 1 day, _____ hrs. _____ min.
75 0 10

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) Kingsville Missouri

10. NAME OF FATHER George Lambert

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

12. MAIDEN NAME OF MOTHER Clina Hess

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

14. INFORMANT (Address) Hub Lambert Front City, Mo.

15. FILED Aug 14, 1934 Mrs. O. H. Bond REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug-11 1934

I HEREBY CERTIFY, That I attended deceased from July 1 1934 to Aug 11 1934
that I last saw her alive on Aug 11, 1934, and that death occurred, on the date stated above, at 12:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Gastric Cancer
131

(duration) _____ yrs. _____ mos. 4 ds.
CONTRIBUTORY (SECONDARY) Gastritis
(duration) 2 yrs. _____ mos. _____ ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

19. WAS THERE AN AUTOPSY? No
WHAT TEST CONFIRMED DIAGNOSIS? Specimen and findings
(Signed) J. J. Ross, M. D.

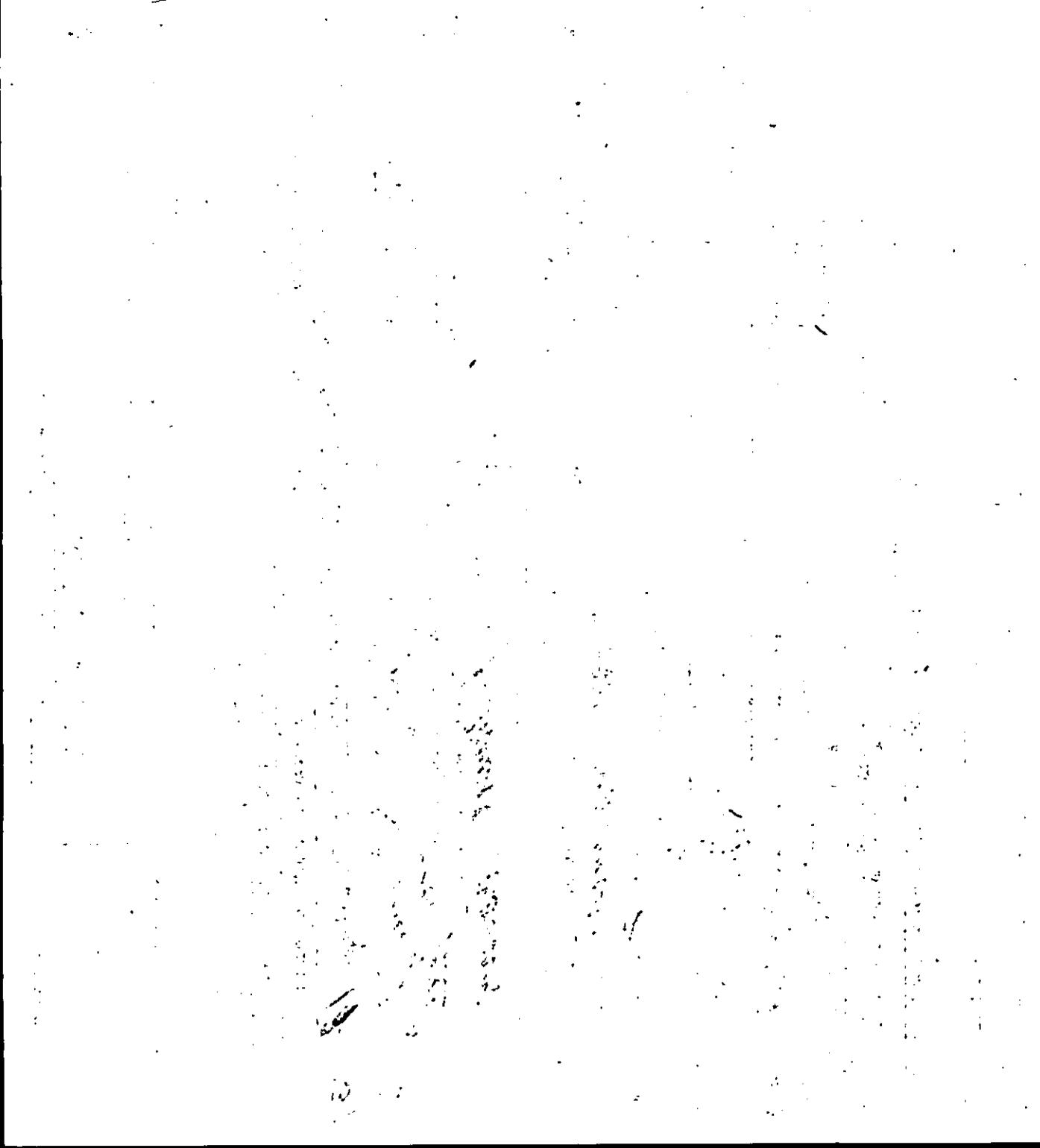
, 19 (Address) Front City Mo

*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 Betchell Cem Aug 12, 34 DATE OF BURIAL

20. UNDERTAKER John C. Dumper ADDRESS Front City

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.



Wirth

WASHINGTON

Dear Sir:

It is essential that death certificates be complete in every particular in order that proper classification may be made. You are therefore requested to make every effort to obtain the following information, indicated by check marks, lacking from the death certificate.

Name: Caroline Gray
Who died at _____ on Aug 11 - 1934
Residence: No. _____ St. _____
(If nonresident, city or town)

Length of residence in city or town where death occurred: Years _____ Months _____ Days _____

Sex F Color or race W Single, married, widowed or divorced: _____

Date of birth _____ Age: Years 75 Months 0 Days 10

Occupation: (a) Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. (b) Industry or business in which work was done, as silk mill, saw mill, bank, etc.

Date deceased last worked at this occupation: rephrased Conna Month _____ Year _____

Birthplace (State or country) _____

Birthplace of father (State or country) Chronic

Birthplace of mother (State or country) _____

Principal cause of death: _____

Other contributory causes of importance rephrased

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

If death was due to external causes (violence) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____
(Specify city or town, county and State)

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

Manner of injury _____

Nature of injury _____

Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____

Name of physician _____

Address of physician _____

Signature of Registrar Mrs. O. H. Bond Date filed Aug 14 1934

This information is sought for statistical purposes only and in order that the official report may be complete and correct. Please reply promptly using the enclosed official envelope which requires no postage.

Very truly yours,

E. T. McGaugh

State Registrar

Special Agent.

Reg. Dist. No. 904

Primary Reg. Dist. No. 6215

S-31795