

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

Do not use this space.

791-2

APR 17 1936

1. PLACE OF DEATH  
 County: St. Louis Registration District No. 283  
 Township: Buffalo Primary Registration District No. 5402  
 City: Cardwell (No. ....) St. .... Ward)

2. FULL NAME Levinis Gray  
 (a) Residence, No. .... St. .... Ward. .... (If nonresident, give city or town and State)  
 Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX F 4. COLOR OR RACE W 5. SINGLE, MARRIED, (WIDOWED OR DIVORCED) (write the word) DK  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF DK  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DK  
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, .... hrs. or .... min.  
67

OCCUPATION  
 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife  
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) DK  
 11. Total time (years) spent in this occupation DK

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Levan West

FATHER  
 13. NAME DK  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

MOTHER  
 15. MAIDEN NAME DK  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) DK

17. INFORMANT J. D. Maitley  
 (ADDRESS) Smith, Mo Route 1

18. BURIAL, CREMATION, OR REMOVAL  
 PLACE Cardwell Cemetery - 31 36

19. UNDERTAKER Howard Undertaker  
 (ADDRESS) Leachville, Ark.

20. FILED 3-15-36 Sturson Registrar.

**MEDICAL CERTIFICATE OF DEATH**

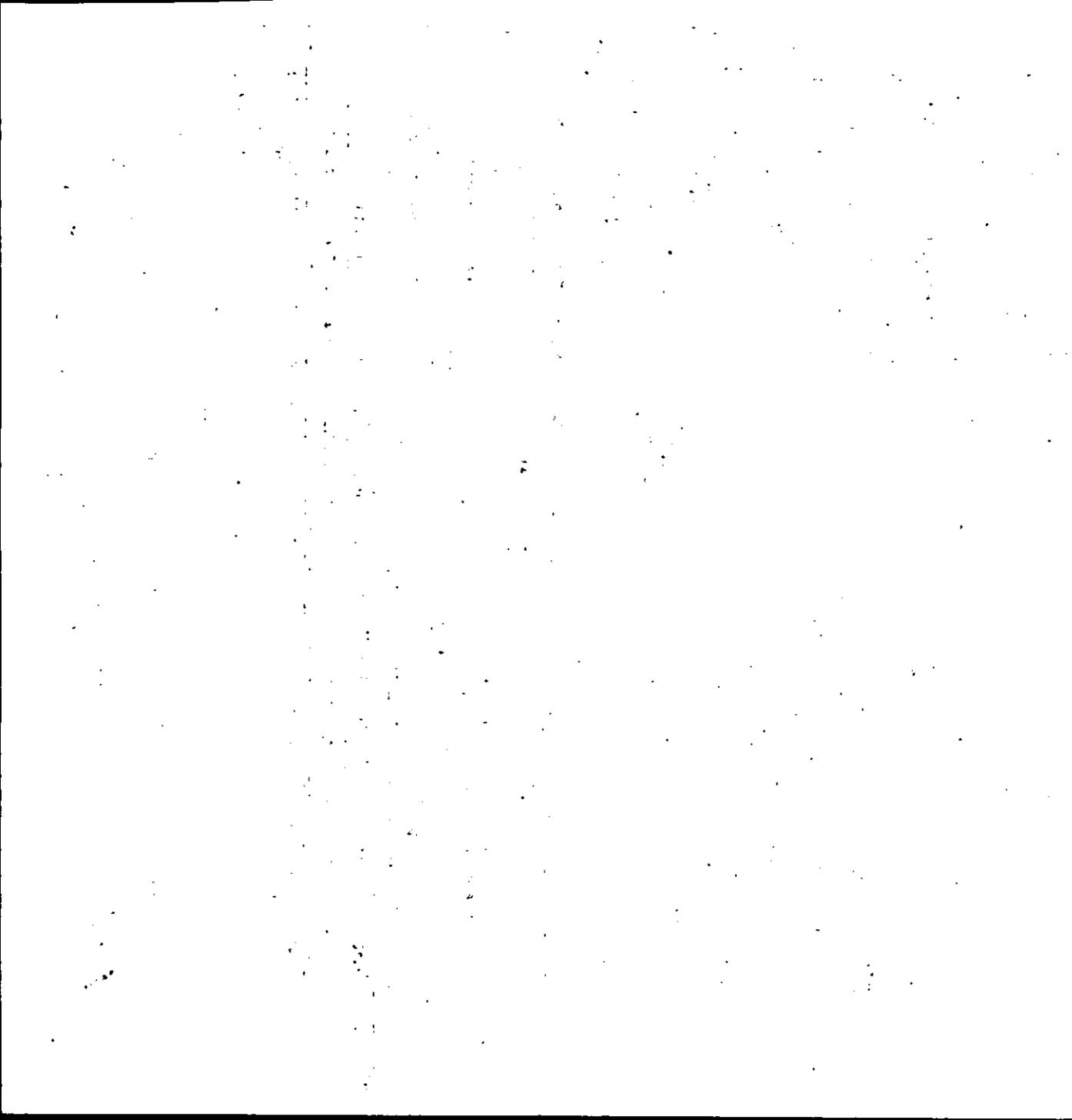
21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-30 36  
 22. I HEREBY CERTIFY, That I attended deceased from 1-29, 1936, to 1-30, 1936  
 I last saw h. or alive on 1-29, 1936. Death is said to have occurred on the date stated above, at 9 A. m.  
 The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis Date of onset

Other contributory causes of importance:  
Nephritis  
Paralysis of left hand 6 yrs  
 Name of operation ..... Date of .....  
 What test confirmed diagnosis? ..... Was there an autopsy? .....

23. 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? Mo (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 .....

24. Was disease or injury in any way related to occupation of deceased? NO  
 If so, specify Wallace D. English, M. D.  
 (Signed) Wallace D. English, M. D.  
 (Address) Cardwell, Mo.



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CERTIFICATE OF DEATH**

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**1. PLACE OF DEATH**

County Worth  
Township Buffalo  
City (No. \_\_\_\_\_) \_\_\_\_\_ St. \_\_\_\_\_ Ward \_\_\_\_\_

Registration District No. 283  
Primary Registration District No. 3402

File No. \_\_\_\_\_  
Registered No. \_\_\_\_\_

**2. FULL NAME**

Linnie Sperry

(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. ds.

**PERSONAL AND STATISTICAL PARTICULARS**

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

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. 67

8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc.

9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.

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)

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE \_\_\_\_\_ DATE \_\_\_\_\_ 19\_\_\_\_

19. UNDERTAKER (ADDRESS)

20. FILED 3-15 1936 W. Newsom Registrar.

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-30, 1936

22. I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_.

I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_. Death is said to have occurred on the date stated above, at \_\_\_\_\_ m.

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

Paralysis caused by previous stroke

Date of onset \_\_\_\_\_

Other contributory causes of importance

Septicemia  
Chronic Intestinal

Name of operation \_\_\_\_\_ Date of \_\_\_\_\_

What test confirmed diagnosis? \_\_\_\_\_ Was there an autopsy? \_\_\_\_\_

23. 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 \_\_\_\_\_

24. Was disease or injury in any way related to occupation of deceased? \_\_\_\_\_

If so, specify \_\_\_\_\_

(Signed) Wallace D. England, M. D.

(Address) Cardwell

SUPPLEMENT

5-791-2