

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.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH **791**

Do not use this space.

AUG 1 1936

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1. PLACE OF DEATH

County..... Registration District No. **1003**
Township..... Primary Registration District No.....
City **St. Louis, Missouri** City Hospital No. **1**

File No.....
Registered No. **6851**
St. Ward)

B. 4722 Harry Gray
2. FULL NAME

(a) Residence, No. **No Home** St. Ward. **X**
(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 **male** 4. COLOR OR RACE **white** 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) **Nov. 29-1886**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 **7** **4**

OCCUPATION
8. Trade, profession, or particular kind of work done, as planner, sawyer, bookkeeper, etc. **none**
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. **Command Laborer**
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) **Illinois**

FATHER
13. NAME **John Gray**

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

MOTHER
15. MAIDEN NAME **Addie Allen**

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

17. INFORMANT **Hosp. Info. M.H. Kent**
(ADDRESS) **City Hospital No. 1**

18. BURIAL, CREMATION, OR REMOVAL
PLACE **Calvary P.C.** DATE **July 5-36**

19. UNDERTAKER **Bridges and Co**
(ADDRESS) **St. Louis, Mo.**

20. FILE **JUL 7 1936** **J.F. Bredeck**
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **7/3/36**, 19

22. I HEREBY CERTIFY, That I attended deceased from **7/3/36** to **7/3/36**, 19
I last saw **him** alive on **7/3/36**, 19. Death is said to have occurred on the date stated above, at **10:45 A**

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

*Myocardial infarction
Paralytic ileus*

Date of onset

Other contributory causes of importance:

810

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?..... 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 **Yes**
(Signed) **Roy Greenbaum**, M. D.
(Address) **City Hospital No. 1**

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