DEC 18 1936

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

Do not use this space.

41034

File No. 16

Registered No. .....

1. PLACE OF DEATH

County: Harrison

Township: Clay

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

Registration District No. 335

Primary Registration District No. 5470

2. FULL NAME Lillian Estella Gray

(a) Residence. No. Harrison Co Mo 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	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
female	white	married

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Nov 28, 1870

7. AGE YEARS	MONTHS	DAYS	If LESS than 1 day, ... hrs. or ..... min.
65	11	29	

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) Madison Twp
(STATE OR COUNTRY) Harrison Co. Mo

PARENTS

10. NAME OF FATHER Geo W. Brock

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

12. MAIDEN NAME OF MOTHER Eliza Jane Harp

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

14. INFORMANT John W Gray
(Address) Albany, Mo

15. FILED 12/7, 1936 L. J. Carter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) Nov 26 1936

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1936, to Nov 26, 1936 that I last saw h. alive on Nov 25, 1936, and that death occurred, on the date stated above, at 5:30 A m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Chronic Interstitial Nephritis

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

CONTRIBUTORY (SECONDARY) .....

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

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

DID AN OPERATION PRECEDE DEATH? No DATE OF .....

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Laboratory tests

(Signed) D. S. Leuf, M. D

, 19 (Address) Cainsville 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	DATE OF BURIAL
Leon. Iowa	11/29 1936
20. UNDERTAKER	**ADDRESS**
Frank S. Stewart	Leon Iowa

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.