

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.

NOV 16 1938

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

33950
Do not use this space.

1. PLACE OF DEATH

(a) County Registration District No. **1003**
(b) Township Primary Registration District No. Registered No. **8936**
(c) City **Saint Louis** (d) Street No. **Peoples Hospital** St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **Mary Gray**

(a) Residence, No. **4475 Enright Avenue** St. **111** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Negro** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Ison Gray**
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Sept. 26, 1870**
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
68 0 13
OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Housewife**
9. Industry or business in which work was done, as 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) **Baton Rouge Louisiana**

FATHER 13. NAME **Daniel Garig**
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Unavailable Virginia**

MOTHER 15. MAIDEN NAME **Mariah Buffington**
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Baltimore Maryland**

17. INFORMANT **Alessenia Gray**
(ADDRESS) **4475 Enright Avenue**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Greenwood Cemetery 10/13/38**

19. FUNERAL DIRECTOR (NAME) (ADDRESS) **Charles A. Gates 4107-09 Finney Avenue**

20. FILED **J. Fredrick**
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **October 9th 1938**

22. I HEREBY CERTIFY, That I attended deceased from **September 27th 1938 to October 9th 1938**
I last saw her alive on **October 9th 1938** Death is said to have occurred on the date stated above, at **8:30 a. m.**
The principal cause of death and related causes of importance were as follows:

Date of onset **Aug 38**
Arterial Heart Disease
Other contributory causes of importance **Sept 38**
Myocardial Infarction

Name of operation **None** Date of
What test confirmed diagnosis **Clinical** Was there an autopsy? **No**

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? **NO**
If so, specify **Samuel Stafford**, M. D.
(Signed) **Samuel Stafford**
(Address) **925 N. Jefferson Avenue**

OCT 13 1938

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

James A. Finney

or by

Registered Apprentice No.

working under my personal supervision.

Signed

James A. Finney

Licensed Embalmer No. 3522

P. O. Address 4107 Finney Avenue

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.