V. S. No. 2. 50M-7-20-37 1 X12004

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK--THIS IS A PERMANENT RECORD

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.

JUN 8 1939

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

18507
Do not use this space.

1. PLACE OF DEATH
(a) County Dent 1 Registration District No. 266
(b) Township Springcreek Primary Registration District No. 5370 Registered No. 39
(c) City (d) Street No. 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 626 Thomas Marion Gregory
(a) Residence, No. St. (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

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): Aug 13 1867
7. AGE: YEARS 71, MONTHS 8, DAYS 20 — If LESS than 1 day, ...hrs. or ....min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc. Express clerk
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): Crawford Co Mo 0

FATHER
13. NAME: Thomas Gregory 0
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Scott Co Mo 0

MOTHER
15. MAIDEN NAME: Mary Ann Baker
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Crawford Co Mo

17. INFORMANT (ADDRESS): Mrs Walter Preist Short Bend Mo

18. BURIAL, CREMATION, OR REMOVAL
PLACE Roberts Cem DATE 5 5/4/39 19

19. FUNERAL DIRECTOR (ADDRESS): Carl K Spencer Salem Mo

20. FILED May 4 1939 F. E. Butler M.D. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR): May 3 1939

22. I HEREBY CERTIFY, That I attended deceased from Sep 10 1938, to April 28, 1939
I last saw him alive on April 28, 1939. Death is said to have occurred on the date stated above, at 2:30 A.M.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Cardiovascular renal Disease	1938

Other contributory causes of importance: Hypertrophy

Name of operation: None Date of: ✓
What test confirmed diagnosis? usual Dyn Was there an autopsy? No

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? No 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: None
Nature of injury:

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) [signature] M. D.
(Address) [signature] Mo
Salem

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I, Carl K Spencer, Licensed Embalmer No. 2370

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. or by , Registered Apprentice No.

working under my personal supervision.

Signed Carl K Spencer

Licensed Embalmer No. 2370

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.)