

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **33972**  
Registrar's No. **8669**

Registration District No. **791** Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County.....  
(b) City or town. **St. Louis**  
(If outside city or town limits, write "RURAL," and name of township)  
(c) Name of hospital or institution: **956 Bates St.** **2**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community. **2 years**  
years, months or days)

3. (a) PRINT FULL NAME. **Ada Gray**

3. (b) If veteran, name war. **----** 3. (c) Social Security No. **None**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**  
6. (b) Name of husband or wife **Oliver Gray** 6. (c) Age of husband or wife if alive **----** years  
7. Birth date of deceased **January 8, 1869**  
(Month) (Day) (Year)

8. AGE: Years **71** Months **9** Days **13** If less than one day  
hr. min.

9. Birthplace **Chester Illinois**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Home**

11. Industry or business

MOTHER FATHER { 12. Name **Parter Bilderback**  
13. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Unknown**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Irene Schlechting**  
(b) Address **4602 Morganford**

17. (a) **Burial** (b) Date thereof **10/23/40**  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation **Caldonia Cem. Sparta, Ill.**

18. (a) Signature of funeral director **Wacker-Helders**  
(b) Address **2331 S. Broadway**

19. (a) **OCT 21 1940** (b) **J.F. Brant**  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County.....  
(c) City or town. **St. Louis** **1**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **956 Bates St.**  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **10** day **21**  
year **1940** hour **12** minute **35 a.m.**

21. I hereby certify that I attended the deceased from **Sept 5, 1940** to **Oct 21, 1940**  
that I last saw her alive on **Oct 21, 1940**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Chr. myocarditis**

Due to.....  
Due to.....

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy.....

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....  
(b) Date of occurrence.....  
(c) Where did injury occur?..... (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (c) Means of injury

23. Signature **Edgar V. Voth** (M. D. or other) **W. A.**  
Address **2805 S. Broadway** Date signed **10-21-40**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

**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, or by

....., Registered Apprentice No.

..... working under my personal supervision.

Signed

*Frank J. Myland*

Licensed Embalmer No.

*2675*

P. O. Address

*St. Louis, Mo.*

**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, fact should be so stated above.**