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FILED DEC 11 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 38297  
Registrar's No. 295

Registration District No. 104

Primary Registration District No. 3008

1. PLACE OF DEATH:

(a) County Callaway  
(b) City or town Fulton  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: State Hospital No 1  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 2 Yrs, 4 mo. 6 days  
(Specify whether years, months or days) 2

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St Louis  
(c) City or town Centaur Station  
(If outside city or town limits, write "RURAL")  
(d) Street No. 0 (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 4  
year 1940 hour 4 minute \_\_\_\_\_ P. M.  
21. I hereby certify that I attended the deceased from Nov-13,  
\_\_\_\_\_, 1938, to Nov-4, 1940;

that I last saw her alive on Nov 4, 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Myocarditis & Indefinite

Due to High Blood Pressure

Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death) A2C

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

PHYSICIAN  
Underline the cause to which death should be charged statistically.

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? 106

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature George W. Fournier (M. D. or other) 1

Address State Hwy #1 Fulton Mo Date signed 11-11-40

3. (a) PRINT FULL NAME Mamie Gregg

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 Married

6. (b) Name of husband or wife Frank Gray 6. (c) Age of husband or wife if alive unknown years

7. Birth date of deceased: March 5 1875  
(Month) (Day) (Year)

8. AGE: Years 65 Months 8 Days 0 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Minnesota  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 1

11. Industry or business \_\_\_\_\_ 9

12. Name Unknown 9

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 Hospital Records

(b) Address State Hwy #1 Fulton Mo

17. (a) Burial (b) Date thereof Nov 12 1940  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Hospital Records

18. (a) Signature of funeral director To be furnished

(b) Address 302 Market St. Fulton Mo

19. (a) 11/12/40 (b) R. N. Crive  
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

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**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.....

Licensed Embalmer No.....

P. O. Address.....

**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.**