

1. PLACE OF DEATH:
(a) County **Scott**
(b) City or town **Grays Point "RURAL" Keisota**
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether years, months or days)

3. (a) PRINT FULL NAME **JACK CARTER GRAY**
3. (b) If veteran, name war. 3. (c) Social Security No.

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **SINGLE**
6. (b) Name of husband or wife. 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased **OCTOBER 17 1865**
(Month) (Day) (Year)

8. AGE: Years **77** Months **9** Days **12** If less than one day hr. min.

9. Birthplace **GRAYS POINT SCOTT CO. MO.**
(City, town, or county) (State or foreign country)

10. Usual occupation **AGRICULTURE**

11. Industry or business

MOTHER FATHER
12. Name **EDMUND GRAY**
13. Birthplace **CINCINNATI OHIO**
(City, town, or county) (State or foreign country)
14. Maiden name **CHARA H. DOOGAN**
15. Birthplace **PHILADELPHIA PENN.**
(City, town, or county) (State or foreign country)

16. (a) Informant **CHARLES W. GRAY**
(b) Address **511 MO. RT. 1**

17. (a) **BURIAL** (b) Date thereof **8-1-43**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **MEMORIAL PARK**

18. (a) Signature of funeral director
(b) Address

19. (a) **8-1-43** (b) **S. J. JAMES**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Scott**
(c) City or town **BOURBON**
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **30** year **1943** hour **9** minute **35 P.M.**

21. I hereby certify that I attended the deceased from **Apr. 21 1943** to **July 30 1943**
that I last saw him alive on **July 30 1943**
and that death occurred on the date and hour stated above.

Immediate cause of death **Chronic Nephritis** Duration **1 yr**

Due to
Due to

Other conditions **Nephrotic**
(Include pregnancy within 3 months of death)

Major findings:
Of operations **1316**
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?

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

23. Signature **S. J. James** (M. D. or other) **M. D.**
Address **St. Louis Mo** Date signed **7-31-43**

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

RECEIVED

District Health Office No. 2,

District File Number 1043-1318

Date Filed 10-15-43

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.....

Glenn Wilson

Licensed Embalmer No. 2828

P. O. Address:.....

Jackson 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.