

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

FILED JUL 8 1944  
Registration District No. 179

Primary Registration District No. 1002

Registrar's No. 2679

1. PLACE OF DEATH:

(a) County Gasconade  
(b) City or town Paris  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
536 & 2 Walnut St  
(If not in hospital or institution, write street number or location) 1  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community Do not know years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Robert A Gray

3. (b) If veteran, name war Do not know 3. (c) Social Security No. Do not know

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced widow  
6. (b) Name of husband or wife Do not know 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased \_\_\_\_\_ 1872  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>			hr. min.

9. Birthplace Do not know (City, town, or county) (State or foreign country) 9

10. Usual occupation Do not know

MOTHER FATHER

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

12. Name Do not know 9

13. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 9

14. Maiden name Do not know

15. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) 9

16. (a) Informant Coroner office

(b) Address 15 Kansas City mo

17. (a) Removal (b) Date thereof June 27 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Rupus mo

18. (a) Signature of funeral director Passantino Bros.

(b) Address 15 Kansas City mo

19. (a) 6-27-44 (b) D.E. Brown  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Gasconade  
(c) City or town Paris city mo 48  
(If outside city or town limits, write "RURAL") 3  
(d) Street No. 536 & Walnut St 8  
(If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_ 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 24  
year 1944 hour 8 minute 22 a.m.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_;  
that I last saw h. Deputy Coroner \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death \_\_\_\_\_  
Arteriosclerotic heart  
Due to \_\_\_\_\_  
Disease.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death) 938

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

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) \_\_\_\_\_  
Means of injury \_\_\_\_\_

23. Signature A. E. Walker (M. D. or other) \_\_\_\_\_  
Address 25 W. 1st Date \_\_\_\_\_

**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.....

*Paul W. Rowe*

Licensed Embalmer No. *2347*

P. O. Address..... *11... City...*

**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.**