

FILED AUG 9 1945 STANDARD CERTIFICATE OF DEATH

State File No. **23594**

Registration District No. **47** Primary Registration District No. **3008**

Registrar's No. **243**

1. PLACE OF DEATH:

(a) County **Callaway**
(b) City or town **Fulton**
(c) Name of hospital or institution: **State Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **7y-0mos-26da**
(Specify whether
In this community **7y-0mos-26da**
years, months or days)

3. (a) PRINT FULL NAME **Harry J. Gregory**
3. (b) If veteran, name war _____ (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **divorced**
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Sept. 6 1882**
(Month) (Day) (Year)

8. AGE: Years **62** Months **10** Days **26** If less than one day _____ hr. _____ min.

9. Birthplace **Chicago, Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Paper Hanger**

11. Industry or business _____

12. Name **Henry C. Gregory**

13. Birthplace **DK**
(City, town, or county) (State or foreign country)

14. Maiden name **DK**

15. Birthplace **DK**
(City, town, or county) (State or foreign country)

16. (a) Informant **Records**

(b) Address _____

17. (a) **Burial** (b) Date thereof **July 28, 1945**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Hospital Grounds**

18. (a) Signature of funeral director **J. B. Stokoe**

(b) Address **302 Market St. Fulton, Mo.**

19. (a) **July 28, 1945** (b) **Jose Moschler**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Callaway**
(c) City or town **Webster Groves**
(If outside city or town limits, write "RURAL")
(d) Street No. **677 Marshall Ave**
(If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **26**
year **1945** hour _____ minute **1255a.** M.

21. I hereby certify that I attended the deceased from **6-1-** 19**42** to **7-25-** 19**45**
that I last saw h. **alive** on **7-25-** 19**45**
and that death occurred on the date and hour stated above.

Immediate cause of death **Bilateral Basal Pneumoniae**
Due to **Acute Tracheobronchitis**

Due to **Septic Aortitis**

Other conditions (include pregnancy within 3 months of death) **30g**

Major findings: Of operations **see above**
Of autopsy **done by Dr. N.P. Neal**

Duration _____
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? _____

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

23. Signature **J. B. Stokoe, M.D.** (M. D. or other)
Address **Fulton** Date signed **7-27-45**

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

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 8-9-45

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.