

No. 2
5-17-39
X36671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED SEP 31 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

State File No. **25689**
Registrar's No. **2377**

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis mo
(b) City or town St. Louis mo
(c) Name of hospital or institution: Peoples Hospital
(d) Length of stay: In hospital or institution 2 days
In this community 2 days
years, months or days (Specify whether)

3. (a) PRINT FULL NAME Daisy Gray
3. (b) If veteran, name war none
3. (c) Social Security No. none

4. Sex Female 5. Color or race Cal
6. (a) Name of husband or wife Frank
6. (b) Name of husband or wife M. Gray
7. Birth date of deceased Aug 17 - 1899
(Month) (Day) (Year)

8. AGE: Years 46 Months 2 Days 18
If less than one day hr. _____ min. _____

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

10. Usual occupation House wife

11. Industry or business Home

12. Name Judge Crawford

13. Birthplace Senatobia Miss
(City, town, or county) (State or foreign country)

14. Maiden name Ernie Walliams

15. Birthplace Senatobia Miss
(City, town, or county) (State or foreign country)

16. (a) Informant Frank M. Gray
(b) Address Venice Island

17. (a) Removal Removal (b) Date thereof 9-1-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Louis Ill
18. (a) Signature of funeral director J. F. Braden
(b) Address St. Louis Ill

19. (a) SEP 1 1945 (Date recorded by registrar)
J. F. Braden (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County Madison
(c) City or town Venice Island
(d) Street No. 500 Slough Road
(e) Citizen of foreign country? no
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month AUG 29 1945
year Aug hour 2:30 minute 0 M.

21. I hereby certify that I attended the deceased from Aug 26 1945
Aug 26 1945 to Aug 29 1945
that I last saw her alive on Aug 29 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Coronary Occlusion
Duration 3 days

Due to _____
Due to _____ 940

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: None
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? _____
(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 Dr. Charles Keenan (M. D.)
Address Argy, Ill Date signed 9/31/45

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER, FATHER

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

MAR 10 1955

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed *Wm E. Jones*

Licensed Embalmer No. *3518*

P. O. Address *St. Louis Ill*

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.

Registration District No. *318*

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:
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution.....
(Specify whether
 In this community.....
years, months or days)

3. (a) PRINT FULL NAME *Daisy Grace*
 3. (b) If veteran, name war.....
 3. (c) Social Security No. *0*

4. Sex *F*
 5. Color or race *B*
 6. (a) Single, widowed, married, divorced *Married*
 6. (b) Name of husband or wife *Frank*
 6. (c) Age of husband or wife if alive *Under 15* years
 7. Birth date of deceased *Aug 11*
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
76 hr. *15* min.

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

10. Usual occupation.....

11. Industry or business.....

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

16. (a) Informant.....

(b) Address.....

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

(c) Place: burial or cremation.....

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

(b) Address.....

19. (a)..... (b) *J. F. Budzek*
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State..... (b) County.....
 (c) City or town.....
(If outside city or town limits, write "RURAL")
 (d) Street No.....
(If rural, give location)
 (e) Citizen of foreign country?..... (Yes or No)
 If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Aug* Day *29*
 year *1929* hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... to....., 19.....
 that I last saw him..... alive on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Due to.....

Due to.....

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

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?
(Specify type of place)

While at work?..... (c) Means of injury.....

23. Signature..... (M. D. or other).....

Address..... Date signed.....

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

SUPPLEMENTARY

1945
S-25489