

3. No. 2
-12-45
5-17-39
P I X47070

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 3448
Registrar's No. 251

FILED FEB 3 1947
Registration District No. 3

Primary Registration District No. 3064

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

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Ferguson
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
429 Wesley Ave. Ferguson, Mo.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Life
years, months or days

3. (a) PRINT FULL NAME Elizabeth Gray
3. (b) If veteran, name war ---- 3. (c) Social Security No. ----

4. Sex F / 5. Color or race W
6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Thomas Gray 6. (c) Age of husband or wife if alive Dec'd years
7. Birth date of deceased July 8 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
68 5 23 hr. min.

9. Birthplace Germany 4
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife 1

11. Industry or business --
12. Name Henry Schmaegel 4
13. Birthplace Germany 1
(City, town, or county) (State or foreign country)
14. Maiden name Mary Hoppe
15. Birthplace Germany 4
(City, town, or county) (State or foreign country)

16. (a) Informant Eleanor Moody
(b) Address Ferguson, Missouri.

17. (a) Burial (b) Date thereof 2/3/47
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Selem Ev. Lutheran Cem.

18. (a) Signature of funeral director White Funeral Home
(b) Address Ferguson, Mo.

19. (a) 2-5-47 (b) Ruth J. Allen M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Louis 96
(c) City or town Ferguson 6
(If outside city or town limits, write "RURAL")
(d) Street No. 429 Wesley Ave. 2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 31
year 1947 hour 7 minute 15 p.m.
21. I hereby certify that I attended the deceased from Dec. 20
1946 to Jan. 31 1947;
that I last saw her alive on Jan. 31 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage 2 days
Duration
Due to Hypertension 5 yrs.
830

Other conditions (Include pregnancy within 3 months of death)
Due to _____

Major findings: Of operations none
Of autopsy none
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 0
23. Signature M. H. Johnson (M. D. or other)
Address Ferguson Mo Date signed 2/3/47

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..... *L. M. White*

Licensed Embalmer No. *3973*

P. O. Address *Gregory, Ind.*

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.