S. No. 2
M—1/47
. 5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED OCT 24 1947

Registration District No. 318

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 1003

State File No. 35763

Registrar's No. 9437

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: Homer G Phillips Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days (Specify whether years, months or days)
In this community Unk

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County ooo
(c) City or town St Louis (If outside city or town limits, write "RURAL") 17
(d) Street No. 2626 N Newstead (If rural, give location) 9
(e) Citizen of foreign country? (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Samuel Gray
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex MALE
5. Color or race Col
6. (a) Single, widowed, married, divorced MARRIED
6. (b) Name of husband or wife Essie Gray
6. (c) Age of husband or wife if alive 59 years
7. Birth date of deceased Unknown (Month) (Day) (Year)
8. AGE: Years ABT 85 Months — Days — If less than one day hr. min.
9. Birthplace (City, town, or county) Tenn (State or foreign country)
10. Usual occupation Labor
11. Industry or business
FATHER
12. Name Unknown
13. Birthplace (City, town, or county) Tenn (State or foreign country)
MOTHER
14. Maiden name Unknown
15. Birthplace (City, town, or county) Tenn (State or foreign country)
16. (a) Informant Essie Gray
(b) Address 4435 Cottage
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Oct 13/47 (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director E H Green
(b) Address 4214 Delmar Blvd
19. (a) OCT 13 1947 (Date received local registrar) (b) J E Bulock (Registrar's signature)

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month October day 8 year 1947 hour 2 minute 30 P.M.
21. I hereby certify that I attended the deceased from October 6, 1947 to October 8, 1947 that I last saw him alive on October 8, 1947 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Prob Cerebral Hemorrhage	Unk
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN — Underline the cause of 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) 0
While at work?
(e) Means of injury
23. Signature O L Daniels (M. D. ~~or other~~)
Address 2601 N Whittier Date signed 10-9-47

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

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 Gustave H. Swan; Registered Apprentice No. 101, working under my personal supervision.

Signed G. A. Green

Licensed Embalmer No. 2963

P. O. Address 4214 DELMAR, BA

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.