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 NOV 29 1947

Registration District No. 377

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6076

State File No. 40511

Registrar's No. 2440

1. PLACE OF DEATH:
(a) County: St. Louis
(b) City or town: Koch (rural)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Robert Koch Hospital 0
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 166 days (Specify whether years, months or days)
In this community: 7 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: 010
(c) City or town: St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No.: 4519 Page 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No) 1
If yes, name country:

3. (a) PRINT FULL NAME: GRAY, NOBLE
3. (b) If veteran, name war:
3. (c) Social Security No.:
4. Sex: Male 2
5. Color or race: Negro
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Dorothy Barnum Gray
6. (c) Age of husband or wife if alive: years
7. Birth date of deceased: October (Month) 6 (Day) 1906 (Year)

8. AGE: Years 41 | Months 1 | Days 17 | If less than one day: hr. min.

9. Birthplace: Fort Smith (City, town, or county) Arkansas (State or foreign country)
10. Usual occupation: Sand Blaster
11. Industry or business:
FATHER
12. Name: William Gray
13. Birthplace: Arkansas (?) (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Marie Halley
15. Birthplace: Arkansas (City, town, or county) (State or foreign country)
16. (a) Informant: Hospital Records
(b) Address: Robert Koch Hospital
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 11-29-47 (Month) (Day) (Year)
(c) Place: burial or cremation: Oakdale
18. (a) Signature of funeral director: Manuel
(b) Address: 4059 Forney
19. (a) 11-28-47 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 23 year 1947 hour 7 minute 05 P. M.

21. I hereby certify that I attended the deceased from 6-10- 1947 to 11-23- 1947 that I last saw him alive on 11-23- 1947 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Pulmonary Tuberculosis	1 yr. (?)
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)
While at work? (e) Means of injury: 0

23. Signature: Bernard Freeman (M. D. or other) M.D.
Address: Robert Koch Hospital Date signed: 11/24/47

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.....

..... Registered Apprentice No.....,

working under my personal supervision.

Signed W. Claude Gordon

Licensed Embalmer No. 3489

P. O. Address 4575 Aldine

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.