MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

N 25 1929

Do not use this space.

17912

1. PLACE OF DEATH

County Henry — Registration District No. 349

Township — Primary Registration District No. ~~0407~~ 4207

City Calhoun (No. ____ St. ____ Ward) — File No. ____ Registered No. 11

2. FULL NAME Dr Alfred A. Gray.

(a) Residence. No. Calhoun Mo St., ____ Ward. (Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. ____ mos. ____ ds. How long in U.S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

EXACTLY: PHYSICIANS should ... Statement of OCCUPATION is very important.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	White	Married

5a. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR)

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ____ hrs. or ____ min.
	61	9	13	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dactor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Grandsen

(STATE OR COUNTRY) Henry County. Missouri

PARENTS

10. NAME OF FATHER Joseph W. Gray

11. BIRTHPLACE OF FATHER (CITY OR TOWN)

(STATE OR COUNTRY) Henry County. Mo.

12. MAIDEN NAME OF MOTHER Clara Head

13. BIRTHPLACE OF MOTHER (CITY OR TOWN)

(STATE OR COUNTRY) Benton County. Mo

14. INFORMANT J. W. Gray

(Address) Clinton. Mo.

15. FILED June 4 1929 Mrs. A. A. Gray deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31st 1929

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to May 31st 1929, that I last saw him alive on May 31st 1929, and that death occurred, on the date stated above, at 10:30 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer.

H I S

(duration) 2 yrs. ____ mos. ____ ds.

CONTRIBUTORY (SECONDARY)

(duration) ____ yrs. ____ mos. ____ ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH?

DID AN OPERATION PRECEDE DEATH? ____ DATE OF ____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS?

(Signed) C. W. Head, M. D

, 19 (Address) Windsor Mo.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Calhoun Mo	June 2 19
20. UNDERTAKER	ADDRESS
Stockton & Clinton Mo	

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

ALL INFORMATION CALLED FOR MUST BE WRITTEN ON THIS SUPPLEMENTARY.

1. PLACE OF DEATH
County Henry Registration District No. 349 File No.
Township Primary Registration District No. 4207 Registered No. 11
City Calhoun (No. , St. Ward)

2. FULL NAME Dr Alfred A. Gray

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident, give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)
M	W	M

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Aug 18 - 1867

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ..hrs. or ..min.
	61	9	13	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN)
(STATE OR COUNTRY)

PARENTS
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (CITY OR TOWN)
(STATE OR COUNTRY)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (CITY OR TOWN)
(STATE OR COUNTRY)

14. INFORMANT
(Address)

15. Filed June 4, 1929 Mrs. A. A. Gray Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 31 1929

17. I HEREBY CERTIFY, That I attended deceased from ..., 19.. to ..., 19..
that I last saw h.. alive on ..., 19.., and that
death occurred, on the date stated above, at ...m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Cancer
Of the Throat.
(duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY)
(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED?
IF NOT AT PLACE OF DEATH
DID AN OPERATION PRECEDE DEATH? DATE OF
WAS THERE AN AUTOPSY?
WHAT TEST CONFIRMED DIAGNOSIS?
(Signed) , M. D.
, 19 (Address)

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

SUPPLEMENTARY

44 CC

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

CERTIFICATE WILL NOT BE ISSUED OR RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETE AS PRESCRIBED BY LAW

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