

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

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.

MAY 8 1925

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

Do not use this space.

12024

1. PLACE OF DEATH
 County Buchanan Registration District No. 85
 Township _____ Primary Registration District No. 1001
 City St. Joseph (No. 1017 Church St. St. _____ Ward _____)
 2. FULL NAME Dr. J. M. McCreary
 (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 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE wh 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married
 5A. IF MARRIED, WIDOWED, OR DIVORCED
 HUSBAND OF Miss Allie Cooney
 (or WIFE OF) _____
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 19 1878
 7. AGE YEARS 59 MONTHS 1 DAYS 29 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Physician
 9. Industry or business in which work was done, as silk mill, saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation 40
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) St. Joe. Mo.
 FATHER 13. NAME Joseph M. McCreary
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bellevue
 MOTHER 15. MAIDEN NAME Mary A. Kelley
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bellevue
 17. INFORMANT Miss Allie M. Cooney
 (ADDRESS) St. Joseph Mo.
 18. BURIAL, CREMATION, OR REMOVAL
 PLACE St. Ann's Cem. DATE 4/20/25
 19. UNDERTAKER Thomas F. Horn
 (ADDRESS) St. Joseph
 20. FILED 4-19-25 1925 John R. Bender
 Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Apr. 18 25
 22. I HEREBY CERTIFY, That I attended deceased from Apr. 17 1925 to Apr. 17 1925
 I last saw him, alive on Apr. 17 1925 Death is said to have occurred on the date stated above, at 4:30 p. m.
 The principal cause of death and related causes of importance were as follows:
Cerebral hemorrhage 9/17
8281
 Other contributory causes of importance:
Arteriosclerosis - both kinds
 Name of operation None Date of _____
 When first confirmed diagnosis: Nov Was there an autopsy? No
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? No
 If so, specify _____
 (Signed) Frank H. Walgen M. D.
 (Address) Emporium Bldg

SEAMEY FUNERAL HOME
ST. JOSEPH MO.