

NOV 2 1938
 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.

1938 REC'D NOV 4 1938

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

36764
 Do not use this space.

1. PLACE OF DEATH
 (a) County St. Louis Registration District No. 784
 (b) Township Jefferson Primary Registration District No. 101 Registered No. 1787
 (c) City Clayton (d) Street No. St. Louis County Hospital St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME RUTH McCREE
 (a) Residence, No. 144 Euclid Avenue St. Webster Groves, Mo.
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 8/2/24

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>14</u>	<u>14</u>	<u>2</u>	<u>27</u>	

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. School
 9. Industry or business in which work was done, as saw mill, bank, etc. Girl
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Webster Groves, Mo.

FATHER
 13. NAME Frank McCree
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ashland, Tenn. /

MOTHER
 15. MAIDEN NAME Lucinda Ross
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) E. Carondelet, Ill.

17. INFORMANT (ADDRESS) Frank McCree
144 Euclid Ave.

18. BURIAL, CREMATION, OR REMOVAL PLACE Father Dickson DATE 11/2 1938

19. FUNERAL DIRECTOR (ADDRESS) J. C. Lewis
Webster Groves, Mo.

20. FILED NOV 2 - 1938 D. R. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10/29 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____
 I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at 12.45 PM
 The principal cause of death and related causes of importance were as follows:

	Date of onset
<u>Tonsillectomy operation.</u>	<u>10/29</u>
	<u>1938</u>

Other contributory causes of importance:
Post-operative hemorrhage causing suffocation. 10/29/38

Name of operation Tonsillectomy Date 10/29/38
 What test confirmed diagnosis Autopsy Was there an autopsy? yes

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. Hospital

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify John C. Lewis
 (Sign) Coroner of St. Louis County, Mo. (Address)

1152

MEPA. SE

10/31 8381

STATEMENT BY LICENSED EMBALMER

88/08/01 J. Lewis Licensed Embalmer No. 2027

hereby certify that the body recorded on the reverse side of this certificate was embalmed by me L. E.

No. or by Registered Apprentice No. working under my personal supervision.

Signed J. Lewis Licensed Embalmer No. 2027

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.)

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
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CERTIFICATE OF DEATH

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1. PLACE OF DEATH

(a) County St Louis Registration District No. 784
 (b) Township Clayton Primary Registration District No. 101 Registered No. 1787
 (c) City Clayton (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number) St. _____
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Ruth McCree

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE negro 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

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.
14 2 27

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

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

13. NAME

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

15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE _____ DATE _____ 19 _____

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED _____ 19 _____

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-29 1938

22. I HEREBY CERTIFY, That I attended deceased from _____ to _____, 19____.

I last saw h. _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Tonsillectomy operation
(for tonsilpharyngitis)
 Date of onset _____

Other contributory causes of importance:

Past Operative Hemorrhage
causing suffocation

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

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? _____

If so, specify John O'Connell M. D.
 (Signed) _____
 (Address) St Louis Mo

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. REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

SUPPLEMENTAL

