

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.

RECD FEB 27 1939

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

3703
Do not use this space.

1. PLACE OF DEATH
 (a) County St. Francois Registration District No. 775
 (b) Township Cery Primary Registration District No. 6070-A Registered No. 10
 (c) City Bonne Terre, Mo. (d) Street No. Bonne Terre Hospital 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 Cata Ruth McCreary
 (a) Residence, No. Samington, Mo. 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 Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed

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

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 28-1873

| | | | | |
|--------|-----------|----------|-----------|----------------------------------|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
| | <u>65</u> | <u>2</u> | <u>22</u> | |

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Retired
 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) St. Francois, Mo.

FATHER 13. NAME James E. McCreary
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Bismarck, Mo.

MOTHER 15. MAIDEN NAME Laura Broadfoot
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Paducah, Ky.

17. INFORMANT (ADDRESS) Paul McCreary, Samington, Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Bonne Terre, Mo. DATE 1/22/39
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Bertram W. W. ... Bonne Terre, Mo.
 20. FILED Jan 22, 1939 N. W. Hawkins Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan. 20, 1939

22. I HEREBY CERTIFY, That I attended deceased from Jan. 14, 1939 to Jan 20, 1939.
 I last saw him alive on Jan 20, 1939. Death is said to have occurred on the date stated above, at 3 P.M.
 The principal cause of death and related causes of importance were as follows:
Hypertensive cardio-vascular disease
General Arterio-sclerosis
 Date of onset 1938

Other contributory causes of importance:
General Arterio-sclerosis

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ 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) R. Richard Couch, M. D.
 (Address) Samington, Mo.

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, *O. J. Claywell*

....., or by

Registered Apprentice No....., working under my personal supervision.

Signed.....

O. J. Claywell
Licensed Embalmer No. *3706*

P. O. Address, *Bonnie Ford M*

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, above space should be left blank.