

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.

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

40822 ✓

DEC 9 1939  
Registration District No. 782

Primary Registration District No. 200

State File No. \_\_\_\_\_  
Registrar's No. 2049

1. PLACE OF DEATH:  
 (a) County ST LOUIS  
 (b) City or town OVERLAND  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: 3301 CALVERT ✓  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
 In this community 4 YEARS (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State MISSOURI (b) County St Louis  
 (c) City or town OVERLAND  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 3301 CALVERT  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

8. (a) PRINT FULL NAME DANIEL BRUCE McCRAY  
 8. (b) If veteran, name war \_\_\_\_\_  
 8. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
 20. DATE OF DEATH: Month Nov day 21<sup>st</sup>  
 year 1939 hour 2:01 minute A. M.  
 21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
 that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
 and that death occurred on the date and hour stated above.

4. Sex Male  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife LILLIE M McCRAY  
 6. (c) Age of husband or wife if alive 69 years  
 7. Birth date of deceased June 8 1868  
 (Month) (Day) (Year)

Immediate cause of death Cerebral Hemorrhage Duration minutes  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

8. AGE: Years 77 Months 5 Days 13  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

Other conditions Cerebral hemorrhage (Hemiplegia) 4 years ago  
 Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

9. Birthplace Helltown (City, town, or county) (State or foreign country) Mo 0  
 10. Usual occupation Carpenter  
 11. Industry or business Self  
 12. Name Unknown  
 13. Birthplace Unknown (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown (City, town, or county) (State or foreign country)

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? \_\_\_\_\_

16. (a) Informant's own signature Paul H McCray  
 (b) Address 3301 Calvert  
 17. (a) Buried (b) Date thereof 11/23/39  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation Springfield, Mo.  
 18. (a) Signature of funeral director Daniel M. Barton  
 (b) Address 252 E. Woodson Rd Overland  
 19. (a) Nov 22 1939 (b) DR. Meyer M. D. D. P. C.  
 (Date received local registrar) (Registrar's signature)

While at work \_\_\_\_\_ (Specify type of place) Means of injury \_\_\_\_\_  
 23. Signature Paul P. Whitener (M. D. or other) M.D.  
 Address 8923 Midland Date signed 11-21-39

**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

*Earl A. Hillman*

Licensed Embalmer No.

*3501*

P. O. Address

*Oreland, Md.*

**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.**