

MARGIN RESERVED FOR BINDING

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

Registration District No. 175

Primary Registration District No. 6070-A

Registrar's No. 90

1. PLACE OF DEATH

(a) County St. Francois

(b) City or town Bonne Terre Mo  
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether \_\_\_\_\_)

In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Francois

(c) City or town Bonne Terre  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_  
(If rural, give location)

(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) PRINTED FULL NAME LAWRENCE EDWARD Mc GRAEL

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. 498-10-4078

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Soldie Mc Grael

6. (c) Age of husband or wife if alive 35 years

7. Birth date of deceased Dec. 13 1898  
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 22  
year 1939 hour 11 minute 45 P. M.

21. I hereby certify that I attended the deceased from Dec 14 1939 to Dec 22 1939; that I last saw him alive on Dec 27 1939 and that death occurred on the date and hour stated above.

8. AGE: Years Months Days If less than one day

41	0	9	hr. min.
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Immediate cause of death Labor Pneu Duration 8 days

Due to Influenza

Due to \_\_\_\_\_

9. Birthplace St. Louis Missouri  
(City, town, or county) (State or foreign country)

10. Usual occupation Laborer

Other conditions (include pregnancy within 3 months of death) 11 W

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name Edward Mc Grael

13. Birthplace Unknown  
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Byington

15. Birthplace Unknown  
(City, town, or county) (State or foreign country)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs Soldie Mc Grael

(b) Address Bonne Terre Mo

17. (a) Burial (b) Date thereof Dec. 25 1939  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Prinerval Cemetery

18. (a) Signature of funeral director Benson and Co

(b) Address 313 Benton St. Bonne Terre

19. (a) Dec. 24, 1939 (b) N. W. Hawkins  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

(Specify type of place)

While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_

23. Signature A. L. Evans (M. D. or other) \_\_\_\_\_

Address Bonne Terre Mo Date signed 12-27-39

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**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.....

*C. J. Claywell*

Licensed Embalmer No.....

*3706*

P. O. Address.....

*Bound Brook, Mo*

**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.**