

SEP 5 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 29707

Registration District No. 784

Primary Registration District No. 119

Registrar's No. 1608

I. PLACE OF DEATH:

(a) County St. Louis
 (b) City or town Webster
 (c) Name of hospital or institution:
509 Lake Ave
 (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)

3. (a) PRINT FULL NAME Ruby Agness Cree 600

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife William D. Cree 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 4th 1869
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
71 1 18 hr. _____ min.

9. Birthplace Toledo Ohio
 (City, town, or county) (State or foreign country)

10. Usual occupation At Home

11. Industry or business _____

12. Name Philo Tilden

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

14. Maiden name Unknown Wilson

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

16. (a) Informant Marshall Cree

(b) Address 509 Lake Ave

17. (a) Burial (b) Date thereof 8/21/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Oak Hill Cemetery

18. (a) Signature of funeral director Robert J. Ambruster

(b) Address 6633 Clayton Road

19. (a) AUG 23 1940 (b) _____
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

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

(c) City or town Webster Groves, Mo
 (If outside city or town limits, write "RURAL")

(d) Street No. 509 Lake Ave
 (If rural, give location)

(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 22nd,
 year 1940 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from Dec. 5-14, 1933 to Aug. 22, 1940
 that I last saw her alive on Aug 20, 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute caustic
disintegration

Due to chronic pyelonephritis
anteno-retralis-chronic cystitis

Due to _____

Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations 131

Of autopsy _____

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature R. P. Gay (M. D. or other) 1

Address 607 N Grand Blvd Date signed 8/23/40

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

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 Edward J. Bockhorst

Licensed Embalmer No. 2502

P. O. Address Clayton 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.