

No. 2
4-13-40
4-17-39
I X23159

DEPARTMENT OF COMMERCE

BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **40495**
10266
Registrar's No.

LEU JAN 15 1941 791

Registration District No.

Primary Registration District No. **1003**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County.....
(b) City or town **St. Louis, Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **6112 Wilson**
(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.....
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **6112 Wilson**
(If rural, give location)
(e) If foreign born, how long in U. S. A.?..... years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Dec** day **17**
year **1940** hour **7** minute **25** P. M.
21. I hereby certify that I attended the deceased from **Sept 8**, 19**37** to **Dec 17**, 19**40**
that I last saw h. or alive on **Dec 11**, 19**40**
and that death occurred on the date and hour stated above.

Immediate cause of death.....
Acute Cardiac Decomposition 2 days
Due to **Chronic Myocarditis** **3 yrs**
Hypertension **3 yrs.**
Due to **Chr. Interstitial Nephritis** **3 yrs.**
Arterio Sclerosis (general)
Other conditions.....
(Include pregnancy within 3 months of death)

Duration
Physician
Underline the cause to which death should be charged statistically.

3. (a) PRINT FULL NAME **Hannah Anna Cragg**

3. (b) If veteran, name war..... 3. (c) Social Security No. **None**

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

6. (b) Name of husband or wife **WILLIAM GRAGG** 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased **October 10, 1863**
(Month) (Day) (Year)

8. AGE: Years **77** Months **2** Days **2** If less than one day hr. min.

9. Birthplace **Illinois**
(City, town, or county) (State or foreign country)

10. Usual occupation **NIL**

11. Industry or business.....

12. Name **W. SAUBAME ROBSON**

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

14. Maiden name **ISABELLE-ELLINGHAM**

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

16. (a) Informant **Clara Cannan**

(b) Address **6112 Wilson Ave.**

17. (a) **Removal** (b) Date thereof **12/14/40**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Coffeen, Ill**

18. (a) Signature of funeral director **Edith E. Ambruster**

(b) Address **4234 Manchester**

19. (a) **DEC 14 1940** (b) **J. F. Brudick**
(Date received local registrar) (Registrar's signature)

Major findings:
Of operations.....
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) (c) Means of injury.....
23. Signature **J. F. Brudick** (M. D. or other) **M.D.**
Address **5950 Southview Ave** Date signed **12-13-40**

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.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed.....

Licensed Embalmer No.

P. O. Address.....

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, fact should be so stated above.