No. 2
1-4-41
17-39
X28390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32645

Registration District No. 1984 Primary Registration District No. 207 Registrar's No. 1911

1. PLACE OF DEATH:

(a) County St. Louis
(b) City or town Carondolet Twnshp.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Koch Hospital. O
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 182 Days (Specify whether
In this community 3 yrs.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County — 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 3010 Pine 9
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME MAGGIE GREEN

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

4. Sex F1
5. Color or race N
6. (a) Single, widowed, married, divorced 2
6. (b) Name of husband or wife —
6. (c) Age of husband or wife if alive — years
7. Birth date of deceased Oct. (Month) 10, (Day) 1902 (Year)

8. AGE: Years 38 Months 10 Days 29 If less than one day hr. min.

9. Birthplace Clio (City, town, or county) / Alabama (State or foreign country)
10. Usual occupation Housemaid
11. Industry or business

FATHER
12. Name Henry McCray
13. Birthplace ? (City, town, or county) 9 ? (State or foreign country)

MOTHER
14. Maiden name Ella McLain
15. Birthplace ? (City, town, or county) 9 ? (State or foreign country)

16. (a) Informant Thomas McCray (McCay)
(b) Address 7 4540 Evans
17. (a) BV Rail (Burial, cremation, or removal) (b) Date thereof 9-15-41 (Month) (Day) (Year)
(c) Place: burial or cremation Teskeggee Ala
18. (a) Signature of funeral director G. D. Richardson
(b) Address 2625 Glasgow
19. (a) SEP 15 1941 (Date received local registrar) G. McGavran M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 9, 1941
year hour 2 35 minute P. M.
21. I hereby certify that I attended the deceased from 7-1-41, 19, to 9-9-41, 19;
that I last saw her alive on 9-9-41, 19;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Chronic Pulmonary Tuberculosis	14 mo.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

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 Willard D. Rowland (M. D. or other) O
Address Koch Hospital Date signed 9-9-41

(Licensed Embalmer's Statement on Reverse Side)

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 A. D. Richardson

Licensed Embalmer No. 2928

P. O. Address 2625 Selvsgrove

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.