

No. 2  
-1-4-41  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **40747**  
**10531**  
Registrar's No.

Registration District No. **791**

Primary Registration District No. **1003**

1. PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town Saint Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
3522 Market Street  
(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 Saint Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 3522 Market Street  
(If rural, give location)  
(e) Citizen of foreign country? ✓ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December day 27  
year 1941 hour 6 minute 30 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.

Immediate cause of death \_\_\_\_\_  
**Coronary Thrombosis;**  
**Chronic Myocarditis with in-**  
**farction (left ventricle.)**

Duration \_\_\_\_\_  
**PHYSICIAN**  
Underline the cause to which death should be charged statistically.

Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)  
Major findings:  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

3. (a) PRINT FULL NAME Joseph Mc Cree

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 471-16-3344

4. Sex Male 2 5. Color or race Col. 6. (a) Single, widowed, married, divorced, Married  
6. (b) Name of husband or wife Elise McCree 6. (c) Age of husband or wife if alive 47 years  
7. Birth date of deceased 5 1871  
(Month) (Day) (Year)

8. AGE: Years 70 Months 10 Days 22  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) Ala (State or foreign country) Salon

10. Usual occupation \_\_\_\_\_

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

MOTHER FATHER { 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)

16. (a) Informant Elise McCree

(b) Address 3522 Market St.

17. (a) Burial (b) Date thereof 1-3-42  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St. Peters Cem.

18. (a) Signature of funeral director F. A. Green

(b) Address 2915 Franklin Avenue

19. (a) DEC 31 1941 (b) J. J. Brudick (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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place) \_\_\_\_\_ (Means of injury) 3  
23. Signature Thomas F. Callahan (M. D. or other) 12/27/41  
Address Deputy Coroner Date signed \_\_\_\_\_

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

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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.....

Licensed Embalmer No. 2963

P. O. Address 2915 Franklin

**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.**