

FILED OCT 9 1942

Registration District No. 132

Primary Registration District No. 3021

State File No.

Registrar's No.

40
1
2
WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH

(a) County Greene

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

(c) Name of hospital or institution: Newton Hosp. #1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution Newton Hosp.
(Specify whether years, months or days)

In this community all life

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Greene

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

(d) Street No. 410 W 22nd
(If rural, give location)

(e) Citizen of foreign country? NO (Yes or No)

If yes, name country _____

3. (a) PRINT FULL NAME Coro Elizabeth McCreary

3. (b) If veteran, name war None

3. (c) Social Security No. _____

4. Sex 71 5. Color or race w

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

6. (b) Name of husband or wife Paul McCreary (dec)

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

7. Birth date of deceased Aug 8 1883
(Month) (Day) (Year)

8. AGE: Years 59 Months 1 Days 3 If less than one day hr. _____ min. _____

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

10. Usual occupation Homemaker

11. Industry or business _____

12. Name Geo Erwin

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

14. Maiden name Josephine Rose

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

16. (a) Informant James McCreary

(b) Address Newton MO

17. (a) Burial (b) Date there Sept 13-42
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 1007. Cem

18. (a) Signature of funeral director James F. ...

(b) Address Newton MO

19. (a) Sept 13-42 (b) Fada Hoffman
(Date specified local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 11 1942 hour 10 minute 10 a M.

21. I hereby certify that I attended the deceased from Jan 1942 to Sept 10 1942 and that I last saw or alive on Sept 10 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Terminal carcinoma

Due to _____

Due to _____

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

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? _____

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

23. Signature J. ... (M. D. or other) _____

Address Newton MO Date signed Sept 10

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. M. Jovian
Licensed Embalmer No. 3453
P. O. Address Sacramento, CA

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

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

NO. 2B
1-8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 30415

Registration District No. 132

Primary Registration District No. 3021

Registrar's No. _____

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town St. Louis
(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 years, months or days) Life

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____

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

(d) Street No. _____ (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Cora Elizabeth McCravy

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

10. DATE OF DEATH: Month Aug, Year 1942, hour _____, minute _____ M.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years _____ months _____ days

7. Birth date of deceased: _____ (Month) _____ (Day) _____ (Year)

21. I hereby certify that I attended the deceased from _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death _____

8. AGE: Years 59, Months 1, Days _____ (If less than one day _____ min.)

Due to Heart (known)

Due to _____

9. Birthplace: _____ (City, town, or county) _____ (State or foreign country)

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

10. Usual occupation _____

11. Industry of business _____

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

Major findings: _____

Of operations 55e

Of autopsy no

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 _____ (M. D. or other)

Address _____ Date signed _____

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

SUPPLEMENTARY

MOTHER FATHER

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

