

No. 2
7-39
X37823

FILED SEP 30 1948 18

Registration District No. _____ Primary Registration District No. 1003 Registrar's No. 8211

1. PLACE OF DEATH:

(a) County St. Louis Mo
 (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:
4330a Gertrude
 (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) 1

3. (a) PRINT FULL NAME Lily McLeod
 3. (b) If veteran, name war No 3. (c) Social Security No. NO

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced No
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased Feb 9 - 1898
 (Month) (Day) (Year)

8. AGE 46 ~~45~~ Years Months 7 Days 15 If less than one day hr. _____ min. _____

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

10. Usual occupation Housewife

11. Industry or business at Home

MOTHER FATHER { 12. Name Wm Chalwood

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

14. Maiden name Jane Wilson

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

16. (a) Informant Stephen McLeod

(b) Address 4430A Gertrude Ave

17. (a) Burial (b) Date thereof 9 29 44
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation New Pickers Cemetery

18. (c), Signature of funeral director KRIEGSHAUSER

(b) Address 4228 So. Kingshighway

19. (a) SEP 26 1948 (b) J. F. Brueck
 (Date received local health officer's certificate) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County oag
 (c) City or town St. Louis
 (If outside city or town limits, write "RURAL") 172
 (d) Street No. 4330a Gertrude Ave
 (If rural, give location) 7
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 24
 year 1944 hour 6.15 AM minute _____ M.

21. I hereby certify that I attended _____ deceased from July 13 1944 to Sept 24 1944
 that I last saw him alive on 9/24/44 and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pulmonary Tuberculosis
 Due to _____
 Due to _____

Other conditions Diphtheria Nucleus
 (Include pregnancy within 3 months of death)
 Major findings:
 Of operations 13
 Of autopsy _____

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

23. Signature Dr. C. H. Houser MD (M. D. or other)
 Address 3657 1/2 Park Ave Date signed 9/29/44

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

Mr. Hanson
5157 E. Grand Ave

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 *Edwin D. McPeters*
Licensed Embalmer No. *3024*
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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. 29591Registration District No. 318Primary Registration District No. 1003Registrar's No. 8216

1. PLACE OF DEATH:

(a) County.....
 (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
 In this community.....
 years, months or days)

3. (a) PRINT
FULL NAME Lily McLeod

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Stephen H. Leod 6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased Feb 9 (Month) 9 (Day) 1906 (Year)

8. AGE: Years 46 Months 7 Days 1 (Less than one day) min.

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

10. Usual occupation

11. Industry or business

MOTHER } 12. Name.....
 FATHER } 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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) NOV 25 1944 (b) J. F. Bruesch
(Date received local registrar) (Registrar's signature)

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.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 14 year 1944 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from 1944 to 1944 that I last saw him alive on 1944 and that death occurred on the date and hour stated above. Immediate cause of death.....

Duration

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 sta-
tistically.

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

