

FILED FEB 13 1945  
Registration District No. 72

Primary Registration District No. 10000

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

1. PLACE OF DEATH:

(a) County Buchanan

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

(c) Name of hospital or institution:  
St. Joseph's Hospital  
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution three days  
In this community Lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")

(d) Street No. 224 E. Hyde Park  
(If rural, give location)

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

3. (a) PRINT FULL NAME Margaret Grace McCain

3. (b) If veteran, name war None

3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 14  
year 1945 hour 11 minute 30 A.M.

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

6. (b) Name of husband or wife David M. McCain (c) Age of husband or wife if alive 55 years (Day) 1893 (Year)

7. Birth date of deceased: October (Month) 4 (Day) 1893 (Year)

21. I hereby certify that I attended the deceased from Dec 26 1944 to Jan 14 1945  
that I last saw her alive on Jan 13 1945  
and that death occurred on the date and hour stated above.

8. AGE:	Years	Months	Days	If less than one day
	<u>52</u>	<u>3</u>	<u>10</u>	hr. _____ min. _____

Immediate cause of death Cerebral Thrombosis Duration 2 wks.

9. Birthplace Buchanan Co., Missouri  
(City, town, or county) (State or foreign country)

Due to Hypertension arterio-sclerotic Cardiovascular disease

10. Usual occupation Housewife

Due to Cholelithiasis

11. Industry or business Home

Other conditions (include pregnancy within 3 months of death) Chy. suppurative

12. Name Crabtree Grace

Major findings: markedly enlarged heart autopsy Arterio-sclerotic kidneys Of autopsy Chy. Cholelithiasis & stones Brain w/ postic

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

14. Maiden name Mary Belle Keling

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

16. (a) Informant David M. McCain (Husband)

(b) Address 224 E. Hyde Park

17. (a) Burial (b) Date thereof 1/19/45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Ashland Cemetery

18. (a) Signature of funeral director John E. Rupp

(b) Address 6054 Pryor Ave., City

19. (a) 1-12-45 (b) Valent P. Puck  
(Date received local registrar) (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) (e) Means of injury \_\_\_\_\_

23. Signature Dr. Grant (M. D. or other)

Address St. Joseph, Mo Date signed 1-18-45

1877

(Licensed Embalmer's Statement on Reverse Side)

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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, ~~only~~.....

....., Registered Apprentice No.....,  
working under my personal supervision.

Signed *John E. Rupp*.....

Licensed Embalmer No. *3986*.....

P. O. Address *St. Joseph, Mo*.....

**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.**