

FILED MAR 3 1945 818

1448

Registration District No.

Primary Registration District No.

1003

Registrar's No.

1. PLACE OF DEATH:

(a) County.....
(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: Barnes Hospital,
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution... 6 days
(Specify whether
In this community... 0
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County 11
(c) City or town McComb Ill
(If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? 2 (Yes or No)
If yes, name country NR

3. (a) PRINT FULL NAME CYRUS PILGRIM McRAVEN

3. (b) If veteran, name war World War #1 3. (c) Social Security No. none

4. Sex M 5. Color W. 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Elizabeth 6. (c) Age of husband or wife if alive 50 years
7. Birth date of deceased May 4 1885
(Month) (Day) (Year)

8. AGE: Years 59 Months 9 Days 9 If less than one day hr. min.

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

10. Usual occupation County Health Officer
McHugh County, Ill.

11. Industry or business
12. Name Joseph McRaven
13. Birthplace Alexander, Ill.
(City, town, or county) (State or foreign country)
14. Maiden name Susan Miller
15. Birthplace Illinois
(City, town, or county) (State or foreign country)

16. (a) Informant Elizabeth McRaven
(b) Address McComb, Illinois

17. (a) Removal (b) Date thereof FEB 13 1945
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation McComb, Ill

18. (a) Signature of funeral director Woodsworth Funeral Home
(b) Address McComb, Ill

19. (a) FEB 13 1945 (b) J. F. Budick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 13
year 1945 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from Feb. 7, 1945, to Feb. 13, 1945;
that I last saw him alive on Feb 13, 1945;
and that death occurred on the date and hour stated above.

Immediate cause of death Broncho-genic carcinoma

Due to...
Due to...
Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations as above
Of autopsy as above

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 JR Bradley (M. D. or _____)
Address Barnes Hospital, Date signed 2/13/45

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

20
17
9

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 *Howard G. Rawland*

Licensed Embalmer No. *3114*

P. O. Address *P. Thomas 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.