

Registration District No. \_\_\_\_\_ Primary Registration District 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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 3 days (Specify whether  
In this community 20 yrs years, months or days)

3. (a) PRINT FULL NAME Silas McCrea  
3. (b) If veteran, name war NONE 3. (c) Social Security No. \_\_\_\_\_

4. Sex MALE 5. Color or race C 6. (a) Single, widowed, married, divorced MARRIED  
6. (b) Name of husband or wife EDNA 6. (c) Age of husband or wife if alive 40 years  
7. Birth date of deceased 5 10 1898  
(Month) (Day) (Year)

8. AGE: Years 48 Months 7 Days 12 If less than one day: hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Job-work

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

MOTHER FATHER

12. Name UNKNOWN

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 Edna McCrea

(b) Address 322 So Compton

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-28-46 (Month) (Day) (Year)

(c) Place: burial or cremation Brimwood

18. (a) Signature of funeral director Bernice Lane  
(b) Address 3103 Washington Blvd

19. (a) DEC 28 1946 (Date received local registrar) (b) J. P. Bredek (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
(a) State Missouri (b) County ST Louis  
(c) City or town St. Louis (If outside city or town limits, write "RURAL")  
(d) Street No. 322 So Compton (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

**MEDICAL CERTIFICATION**  
20. DATE OF DEATH: Month Dec. day 22  
year 1946 hour 10 minute 30 A. M.

21. I hereby certify that I attended the deceased from 12-19- 19 46 to 12-22 19 46  
that I last saw him alive on Dec. 22 19 46  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration Undet.

Due to \_\_\_\_\_  
Due to \_\_\_\_\_

Other conditions: Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations \_\_\_\_\_  
Of autopsy Yes

**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? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(e) Means of injury \_\_\_\_\_

23. Signature C. P. Williams (M. D. or other) \_\_\_\_\_  
Address 2601 N. Whittier Date signed 12/26/46

**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.....

*H. Claude Gordon*

Licensed Embalmer No. *3489*

P. O. Address. *4575 Alder*

**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.**