S. No. 2
—1/47
5-17-39

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

42724

State File No.

FILED JAN 5 1948

Registration District No. 318

Primary Registration District No. 3058

Registrar's No. 176

1. PLACE OF DEATH:
(a) County St. Charles
(b) City or town St. Charles (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Joseph Hospital (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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County St. Charles 92
(c) City or town St. Charles (If outside city or town limits, write "RURAL") 9
(d) Street No. % St. Joseph Hospital (If rural, give location) 3
(e) Citizen of foreign country? no (Yes or No) 0
If yes, name country

3. (a) PRINT FULL NAME Mary McCrady
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 S
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Oct. 5 (Month) - 1947 (Day) (Year)

8. AGE: Years | Months | Days | If less than one day 17 hr. min.

9. Birthplace St. Charles (City, town, or county) Mo. (State or foreign country)
10. Usual occupation nil
11. Industry or business
FATHER
12. Name Frank McCrady
13. Birthplace St. Louis (City, town, or county) Mo. (State or foreign country)
MOTHER
14. Maiden name Cecelia Henderson
15. Birthplace Robertson (City, town, or county) Mo. (State or foreign country)
16. (a) Informant Frank McCrady
(b) Address Robertson, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-8-47 (Month) (Day) (Year)
(c) Place: burial or cremation St. Marys Cemetery
18. (a) Signature of funeral director Baumann Bros Inc
(b) Address 2504 Woodson Rd - Overland Mo.
19. (a) 10/8/47 (Date received local registrar) (b) Fannie Hamilton (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 6
year 1947 hour minute M.
21. I hereby certify that I attended the deceased from Oct 5, 1947 to Oct 6, 1947
that I last saw her alive on Oct 6, 1947;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Prematurity and fetal atelectasis	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN
Underline the cause of 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)
While at work? (e) Means of injury 0
23. Signature Jos L. Faith M.D. (M. D. or other)
Address 201 N Fifth St St Charles Date signed 10/7/47

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

Jefferson City Printing Co.

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 9,
District File Number----------
Date Filed----------

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was not embalmed by me, or by.....
..... Registered Apprentice No.....,
working under my personal supervision.

Not Embalmed

Signed Don Marler

Licensed Embalmer No. 4438

P. O. Address Everland, 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.