

FILED SEP 15 1950

THE DIVISION OF HEALTH OF MISSOURI
 STANDARD CERTIFICATE OF DEATH

State File No. 28438

318 1003

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. 1003 Registrar's No. 7619

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN ST. LOUIS 3199	
d. FULL NAME OF HOSPITAL OR INSTITUTION 4220 Maryland Dr.		1. STREET ADDRESS (If rural, give location) 4220 MARYLAND AVE	
3. NAME OF DECEASED (Type or Print) a. (First) Carrie b. (Middle) Viola c. (Last) Mc Gregor		4. DATE OF DEATH (Month) (Day) (Year) Sept 7 1950	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 13, 1862
9. AGE (In years last birthday) 87		10. MONTHS 11	11. DAYS 25
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Acton Indiana
12. CITIZEN OF WHAT COUNTRY?		13a. FATHER'S NAME Charles Anderson	
13b. MOTHER'S MAIDEN NAME Unknown		14. NAME OF HUSBAND OR WIFE Charles Mc Gregor	
15. HAS DECEASED EVER IN U.S. ARMED FORCES? (When no. or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT'S SIGNATURE OR NAME Mrs. Mc Gregor		ADDRESS 4220 Maryland	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) Senility	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR H3X			
22. I hereby certify that I attended the deceased from Feb. 4 1950, to Sept 7, 1950, that I last saw the deceased alive on Sept 2, 1950, and that death occurred at 3:59 p.m., from the causes and on the date stated above.			
23a. SIGNATURE Robert J. Farrell M.D.		23b. ADDRESS 624 N. Union	
23c. DATE SIGNED 9/8/50			
24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		24b. DATE Sept 9, 1950	
24c. NAME OF CEMETERY OR CREMATORY Palhalla Crematory		24d. LOCATION (City, town, or county) (State) St. Charles Rock Road Mo.	
DATE REC'D BY LOCAL REG. SEP 8 1950 G.		REGISTRAR'S SIGNATURE J. B. Sasater	
25. FUNERAL DIRECTOR'S SIGNATURE Bull-Campbell Mortuary		ADDRESS 4215 Lindell	

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

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed

Rev. P. Campbell

Licensed Embalmer No. *3881*

P. O. Address *St. Louis, 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.