

FILED OCT 21 1950

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 35065  
8687  
Registrar's No. \_\_\_\_\_

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

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	
c. LENGTH OF STAY (In this place)		2259	
d. FULL NAME OF HOSPITAL OR INSTITUTION 1327 Cole St.		d. STREET ADDRESS (If rural, give location) 1827 Cole St.	

3. NAME OF DECEASED (Type or Print) Mary	a. (First)	b. (Middle)	c. (Last) McCray	4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1950
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5. SEX Female 3	6. COLOR OR RACE Colored	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH July 10, 1875	9. AGE (In years last birthday) 75	10. UNDER 1 YEAR Months 3	10. UNDER 1 YEAR Days 1	10. UNDER 1 YEAR Hours	10. UNDER 1 YEAR Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unemployed	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Wash	12. CITIZEN OF WHAT COUNTRY? U. S. A.
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13a. FATHER'S NAME Unknown	13b. MOTHER'S MAIDEN NAME Unknown	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME Ora Short	ADDRESS 1327 Cole
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 5 days
	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Hypertension DUE TO (c) Chro Blumer's Disease		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		Unknown	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? 592X
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22. I hereby certify that I attended the deceased from June 1, 1950, to Oct 11, 1950, that I last saw the deceased alive on Oct 11, 1950, and that death occurred at 4:40 p.m., from the causes and on the date stated above.

23a. SIGNATURE S. E. Moore M.D.	(Degree or title)	23b. ADDRESS 809 N. Jefferson	23c. DATE SIGNED 10/13/50
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-16-50	24c. NAME OF CEMETERY OR CREMATORY Oakdale Cemetery	24d. LOCATION (City, town, or county) (State) LeMay Mo
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DATE REC'D BY LOCAL REG. OCT 14 1950	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE E. B. France	ADDRESS 1221 N. Grand
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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.....

.....  
working under my personal supervision.

Student Embalmer No.....

Signed.....

*Lawrence Cronin*

Signed.....  
Student Embalmer

Licensed Embalmer No. 4755

P. O. Address 1221 N. Green

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.