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ev. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 19 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2832**
Registrar's No. **950**

Registration District No. _____ Primary Registration District No. **1003**

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Peoples Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **6 days**
In this community **26 years**
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Mo.** (b) County **000**
(c) City or town **St. Louis** **26 17**
(If outside city or town limits, write "RURAL")
(d) Street No. **1715 N. II th. St.** **9**
(If rural, give location) **0**
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME **Bill McGee.**
3. (b) If veteran, name war **no** 3. (c) Social Security No. **494-09-8972**

4. Sex **Male** 2 5. Color or race **Col.** 6. (a) Single, widowed, married, divorced **Married**
6. (b) Name of husband or wife **Minnie McGee** 6. (c) Age of husband or wife if alive **50** years
7. Birth date of deceased **June, 15, 1899**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
47 7 12 hr. min.

9. Birthplace **Tyler Town Miss.**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **Lincoln McGee.**

13. Birthplace **? Miss.**
(City, town, or county) (State or foreign country)

14. Maiden name **Thursday Byrant**

15. Birthplace **? Miss.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Minnie McGee**
(b) Address **1715 N. II th. St.**

17. (a) **Burial** (b) Date thereof **Jan. 31, 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **MoCombs City, Miss.**

18. (a) Signature of funeral director **Wright's Funeral Home.**
(b) Address **3100 Easton Ave.**

19. (a) **JAN 28 1947** (b) **J. F. Budek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan.** day **27**
year **1947** hour **8:45** minute **A.** M.

21. I hereby certify that I attended the deceased from **1/18** to **1/27** 19**47**
that I last saw him alive on **1/27** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cerebral apoplexy**
hypertension ?
Due to _____

Due to **ph**
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: **none**
Of operations _____
Of autopsy **no**

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) (M. D. or other)
23. Signature **J. F. Budek** Date signed **1/27/47**

Address **3126 Chautauque**

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

MOTHER FATHER

APR 5 1948

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 Arthur L. Heilliard

Licensed Embalmer No. 4221

P. O. Address 1154 Bayard ave

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.