

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:

(a) County _____

(b) City or town **SAINT LOUIS:**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
RESIDENCE: 5053 WESTMINSTER PL.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether years, months or days)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI:** (b) County _____

(c) City or town **SAINT LOUIS:** **12** **17**
(If outside city or town limits, write "RURAL")

(d) Street No. **5053 WESTMINSTER PLACE:** **9**
(If rural, give location)

(e) Citizen of foreign country? **NO.** (Yes or No) **0**
If yes, name country _____

3. (a) PRINT FULL NAME **CATHARINE CLARK CRAIB**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE**

6. (b) Name of husband or wife **JOHN C. CRAIB** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **SEPTEMBER 26 1859.**
(Month) (Day) (Year)

8. AGE: - Years	Months	Days	If less than one day
87	7	7	hr. _____ min. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **May** day **3**
year **1947** hour **3:30** minute **P** M.

21. I hereby certify that I attended the deceased from **Apr. 25** 19**47** to **May 3** 19**47**;
that I last saw her alive on **May 3** 19**47**;
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral Hemorrhage Left side of Brain	7 days
Due to General & Cerebral Arterio Sclerosis	
Other conditions (include pregnancy within 3 months of death)	

9. Birthplace **INGERSOL ONTARIO CANADA**
(City, town, or county) (State or foreign country)

10. Usual occupation **AT HOME**

11. Industry or business _____

MOTHER FATHER

12. Name **JOHN T. FERGUSON**

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

14. Maiden name **JEANIE KERR**

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

16. (a) Informant **BALFOUR STUART CRAIB**
(b) Address **5053 WESTMINSTER PLACE.**

17. (a) **BURIAL** (b) Date thereof **MAY 5 1947.**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **LAKE CHARLES CEMETERY**

18. (a) Signature of funeral director **C. R. LUPTON & SONS:**
(b) Address **7233 DELMAR BLVD. UNIVERSITY CITY.**

19. (a) **MAY 5 1947** (b) **J. F. Brudack**
(Date received local registrar) (Registrar's signature)

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(c) 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 **Hiram L. Heston** (M. D. or other) **M.D.**
Address **3720 Washington** Date signed **5/5/47**

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

3720 Washington
JE 1551
2 to 4 P.M.

Dr. William Leggett

MON - P.M.

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 *Raymond L. Morris*

Licensed Embalmer No. *4330*

P. O. Address *Maplewood, N.J.*

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.