

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

5052
 Do not use this space.

1. PLACE OF DEATH **REC'D MAR 14 1938**

(a) County..... Registration District No.....
 (b) Township..... Primary Registration District No..... Registered No. **1697**
 (c) City **St. Louis** (d) Street No. **5029 Cabanne Ave.** St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME **H. Seymour Crawford 616**
 (a) Residence, No. **5029 Cabanne Ave.** St. **12**
 (Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Male** 4. COLOR OR RACE **White** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Married**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **Clara Crawford**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **March 21, 1868**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
69 10 24

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Portrait-Artist**
 9. Industry or business in which work was done, as saw mill, bank, etc.....
 10. Date deceased last worked at this occupation (month and year)..... 11. Total time (years) spent in this occupation.....

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Mo. 0**

FATHER 13. NAME **James E. Crawford 5**

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ireland 1**

MOTHER 15. MAIDEN NAME **Amanda J. Patterson**

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) **Ohio**

17. INFORMANT (ADDRESS) **Mrs. Clara Crawford 5029 Cabanne Ave.**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Valhalla** DATE **Feb. 19, 1938**

19. FUNERAL DIRECTOR (ADDRESS) **Arthur J. Donnelly Undt. Co. 3840 Lindell Blvd.**

20. FILED **FEB 17 1938** *J. D. Bredich*

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **Feb. 15, 1938** 19

22. I HEREBY CERTIFY, That I attended deceased from **Jan 1st**, 1936, to **Feb 1st**, 1938. I last saw him alive on **Feb 1st**, 1938. Death is said to have occurred on the date stated above, at **8:10 PM.**

The principal cause of death and related causes of importance were as follows:

Chronic myocarditis
Chronic sclerosis
Chronic nephritis
 Date of onset **1/15/36**
 Other contributor/causes of importance: **1/1/37**

Name of operation **none** Date of **X**
 What test confirmed diagnosis? **normal for his age** Was there an autopsy? **no**

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? **no** Date of injury **X**, 19...
 Where did injury occur? **X** (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury **X**
 Nature of injury **X**

24. Was disease or injury in any way related to occupation of deceased? **no**
 If so, specify **X**
 (Signed) **William T. Hinrichs**, M. D.
 (Address) **3500 N Grand**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I, W.H. Van Matte, Licensed Embalmer No. 2825

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Me

L. E.

No. _____ or by _____, Registered Apprentice No. _____

working under my personal supervision.

Signed W.H. Van Matte

Licensed Embalmer No. 2825

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.)