

REC'D OCT 12 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

30364
Do not use this space.

1. PLACE OF DEATH **Homer G. Phillips Hospital**

(a) County..... Registration District No.....

(b) Township..... Primary Registration District No..... Registered No. **7801**

(c) City **St Louis** (d) Street No. **City Hospital #2** St. **1251**
(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 **Lillian Crump**

(a) Residence, No. **2933 Pine Blvd** St. **21** (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **Col** 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) **Widowed**

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF **William Crump**

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) **Aug 15th 1900**

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
	38	0	15	

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. **Maid**

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) **Rollingfork** (STATE OR COUNTRY) **Miss**

FATHER

13. NAME **William Smith**

14. BIRTHPLACE (CITY OR TOWN) **Edwards** (STATE OR COUNTRY) **Miss**

MOTHER

15. MAIDEN NAME **Nettie Williams**

16. BIRTHPLACE (CITY OR TOWN) **Okolona** (STATE OR COUNTRY) **Miss**

17. INFORMANT **Janie Holmes** (ADDRESS) **2933 Pine Blvd**

18. BURIAL, CREMATION, OR REMOVAL PLACE **Washington Park** DATE **Sept 3 1938**

19. FUNERAL DIRECTOR (NAME) **Jas. H. Randle & Son** (ADDRESS) **3132 1/2 Bell Ave**

20. FILED **SEP 9 1938** **J. B. Buehler** Local Registrar

MEDICAL CERTIFICATE OF DEATH

No Bleeding

21. DATE OF DEATH (MONTH, DAY, AND YEAR) **8/30/38** 19.....

22. I HEREBY CERTIFY, That I attended deceased from 19....., to 19.....

I last saw h..... alive on 19..... Death is said to have occurred on the date stated above, at **11:00 P.M.**

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

Fibrosis of Lung (Tubercular) Date of onset

Edema of Lung

Other contributory causes of importance: **NO**

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy? **yes**

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? **No**
If so, specify **Joseph M. Dink**
(Signed) **Joseph M. Dink** M.D.
(Address) **Deputy Coroner**

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 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

A. M. Green

Licensed Embalmer No.

1173

P. O. Address

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, above space should be left blank.