

REC'D JAN 11 1939

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

41296

Do not use this space.

791

1008

10988

## 1. PLACE OF DEATH

(a) County..... Registration District No.....  
 (b) Township..... Primary Registration District No.....  
 (c) <sup>City</sup> St. Louis Mo...... (d) Street No. 3624 Garfield 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 Sophia May Crotser

(a) Residence, No. 3624 Garfield Ave. St. III (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 <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Married</u>
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF <u>Calvin Crotser</u>		
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>May 13, 1868</u>		
7. AGE YEARS <u>70</u>	MONTHS <u>8</u>	DAYS <u>7</u>
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. <u>Housewife</u>		
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) <u>Aug. 1938</u>		11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) South Bend Ind.  
(STATE OR COUNTRY)13. NAME Wm. Stackman14. BIRTHPLACE (CITY OR TOWN) Germany  
(STATE OR COUNTRY)15. MAIDEN NAME Unknown16. BIRTHPLACE (CITY OR TOWN) Germany  
(STATE OR COUNTRY)17. INFORMANT Mrs. Dell Rona  
(ADDRESS) 3624 Garfield Ave.18. BURIAL, CREMATION, OR REMOVAL PLACE Lake Charles DATE Dec. 22, 193819. FUNERAL DIRECTOR (NAME) Albert H. Hoppe Inc.  
(ADDRESS) 4700 Washington Blvd.20. FILED J. B. Buckner  
Local Registrar.

## MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-20 193822. I HEREBY CERTIFY, That I attended deceased from 12-13, 1938, to 12-21, 1938I last saw h. ex alive on 12-17, 1938. Death is said to have occurred on the date stated above, at 530 A.M.

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

Carcinoma Breast - RxDate of onset  
7

Other contributory causes of importance:

Name of operation Naut. Date of.....  
What test confirmed diagnosis?..... Was there an autopsy?.....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.....(Signed) J. B. Buckner, M. D.(Address) 607 W. 11th

**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 *J. G. Sullivan*  
Licensed Embalmer No. *1122*  
P. O. Address *4704 Washington St*

**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.**

FILL IN ANSWERS TO ALL SPACES  
CHECKED IN RED PENCIL.

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

41296  
Do not use this space.

1. PLACE OF DEATH

(a) County..... Registration District No. 791  
(b) Township..... Primary Registration District No. 1003 Registered No. 10988  
(c) City St Louis (d) Street No..... 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

Sophia May Crotsler  
(a) Residence, No. .... St.  (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 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) CROTSER

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Calvin Crotsler

6. DATE OF BIRTH (MONTH, DAY, AND YEAR)

7. AGE YEARS MONTHS DAYS If LESS than 1 day, .....hrs. or .....min.  
70 7 7

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

FATHER 13. NAME

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

MOTHER 15. MAIDEN NAME

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

17. INFORMANT (ADDRESS)

18. BURIAL, CREMATION, OR REMOVAL

PLACE ..... DATE ..... 19

19. FUNERAL DIRECTOR (ADDRESS)

20. FILED 01/9/39 J. F. Bredich Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-20-38

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

I last saw h..... alive on....., 19..... Death is said

to have occurred on the date stated above, at.....m.

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

Date of onset

Other contributory causes of importance:

Name of operation ..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy?.....

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?.....

If so, specify.....

(Signed) J. R. Kennedy M. D.

(Address) 607 1/2 N. Grand

SUPPLEMENTARY

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.  
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.

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