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.

REC'D FEB 10 1939

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

Do not use this space. 399

791

1003

1. PLACE OF DEATH
   (a) County ..... Registration District No. 1003
   (b) Township ..... Primary Registration District No. ..... Registered No. .....
   (c) City St Louis, Mo (d) Street No. St. Johns Hospital 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 630 Hugh Crotty
   (a) Residence, No. St Johns Hospital 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): Single

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF: —

6. DATE OF BIRTH (MONTH, DAY, AND YEAR): Mch. 5 - 1858

7. AGE: Years 80 | Months 10 | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Laborer
9. Industry or business in which work was done, as saw mill, bank, etc. Retired
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): Ireland

FATHER
13. NAME: John Crotty
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

MOTHER
15. MAIDEN NAME: Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY): Ireland

17. INFORMANT (ADDRESS): Sister M. Bonifenture St Johns Hospital

18. BURIAL, CREMATION, OR REMOVAL
PLACE Calvary DATE Jan 13th 1939

19. FUNERAL DIRECTOR (NAME) L. Mullen (ADDRESS) 5165 Delmar Blvd

20. FILED JAN 12 1939 J. F. Budick Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-11- 1939

22. I HEREBY CERTIFY, That I attended deceased from 1-5- 1939, to 1-11- 1939
I last saw him alive on 1-11- 1939. Death is said to have occurred on the date stated above, at 12 P m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
Arteriosclerotic	
Heart Disease	

Other contributory causes of importance: N D

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) Carl H. Reis M. D.
(Address) 3604 Woolsey

(Licensed Embalmer's Statement on Reverse Side)

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. John Ketter

Licensed Embalmer No. 3880

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.