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S. No. 2
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5-17-39
-I X21492

AUG 25 1940
DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

23324

State File No. _____

Registration District No. **791**

Primary Registration District No. **1003**

Registrar's No. **5769**

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location) 1
(d) Length of stay: In hospital or institution 19 Days
(Specify whether _____)
In this community Life
years, months or days)

8. (a) PRINT FULL NAME Wilma Crabtree 613

8. (b) If veteran, name war No 3. (c) Social Security No. None

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced S

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

7. Birth date of deceased Aug. 6, 1938
(Month) (Day) (Year)

8. AGE: Years 1 Months 10 Days 29 If less than one day _____ hr. _____ min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name William Crabtree

18. Birthplace St. Louis, Mo
(City, town, or county) (State or foreign country)

14. Maiden name Glennia Goodman

15. Birthplace New Crabtree Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address 1341 S. 13th St

17. (a) Burial (b) Date thereof 7/8/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old S.S. Peter & Paul Cem

18. (a) Signature of funeral director W. M. McLaughlin
(b) Address 2301 Lafayette Ave

19. (a) JUL 8 1940 (b) _____
(Date received local registrar) (Place of registration)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
(c) City or town St. Louis 22
(If outside city or town limits write "RURAL")
(d) Street No. 1341 S. 13th Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 5, year 1940 hour 5:10 minute A. M.

21. I hereby certify that I attended the deceased from June 17, 1940 to July 5, 1940, that I last saw her alive on July 5, 1940, and that death occurred on the date and hour stated above.

Immediate cause of death Tuberculous Meningitis 48?

Due to Tuberculous Pneumonia - Child hood type

Other conditions Scrophala mesenteric adenitis
(Include pregnancy within months of death)

Major findings: Of operations _____
Of autopsy Meningitis, etc.

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

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

(a) 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 E. E. Thibault _____
Address 1515 Lafayette Date signed 7/5/40

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

MOTHER FATHER

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 L.R. Cooper
Licensed Embalmer No. 3633
P. O. Address 2317 Lafayette

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.