

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

1. PLACE OF DEATH:  
 (a) County St. Louis  
 (b) City or town Lemay  
 (c) Name of hospital or institution 212 Horn Ave.  
 (d) Length of stay: In hospital or institution 33 yrs.  
 In this community 33 yrs.

3. (a) PRINT FULL NAME Annie Crouther  
 (b) If veteran, name war No.  
 (c) Social Security No. No.

4. Sex Female  
 5. Color or race White  
 6. (a) Single, widowed, married, divorced Married  
 (b) Name of husband or wife Charles Crouther  
 (c) Age of husband or wife if alive 76 years  
 7. Birth date of deceased Feb. 27, 1867

8. AGE: Years 73 Months 5 Days 4  
 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace New Orleans La.  
 (City, town, or county) (State or foreign country)

10. Usual occupation House work

11. Industry or business at home

12. Name Unknown

13. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

14. Maiden name Unknown

15. Birthplace Unknown  
 (City, town, or county) (State or foreign country)

16. (a) Informant Charles Crouther  
 (b) Address 212 Horn Ave.

17. (a) Burial (b) Date thereof 8/3/40  
 (Burial, cremation, or removal) (Month) (Day) (Year)  
 (c) Place: burial or cremation mSunset Burial Pk.

18. (a) Signature of funeral director Fendler Und Co.  
 (b) Address 7420 Michigan Ave.

19. (a) AUG - 1 1940 (b) R. M. [Signature]  
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:  
 (a) State Missouri (b) County St. Louis  
 (c) City or town Lemay  
 (d) Street No. 212 Horn Ave.  
 (e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31<sup>ST</sup> year 1940 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 6-12-40 to 7-31-40

that I last saw him alive on 7-31-40 and that death occurred of the date and hour stated above.  
 Immediate cause of death Myocardial Infarction  
Chronic  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_  
 Of autopsy 131

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? \_\_\_\_\_

23. Signature [Signature] (Specify type of place) \_\_\_\_\_  
 While at work \_\_\_\_\_ Means of injury \_\_\_\_\_  
 (M. D. or other) \_\_\_\_\_  
 Address 2139 [Address] Date signed 8-1-40

Dr. EADS  
6639 Virginia

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**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.....

Licensed Embalmer No.....

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, fact should be so stated above.**