

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH  
1003

State File No. 34264  
Registrar's No. 8961

Registration District No. 791

Primary Registration District No. \_\_\_\_\_

PLACE OF DEATH:

(a) County \_\_\_\_\_  
(b) City or town St. Louis  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
1642 S. Spring Ave  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community \_\_\_\_\_ years, months or days)

3. (a) PRINT FULL NAME Frank M. Crane

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

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife Single 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased January 3 1855  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
85 9 27 hr. min.

9. Birthplace Connecticut (City, town, or county) (State or foreign country)

10. Usual occupation Foreman

11. Industry or business Retired

MOTHER FATHER { 12. Name John Crane

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

14. Maiden name Cynthia Renault (State or foreign country)

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

16. (a) Informant's own signature Frank Crane

(b) Address 1642 S. Spring Ave

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Nov 1 1940 (Month) (Day) (Year)

(c) Place: burial or cremation Bellefontaine Cemetery

18. (a) Signature of funeral director Petz Brothers

(b) Address 3029 Lafayette Ave

19. (a) OCT 31 1940 (Date received local registrar) (b) J. P. [Signature] (Registrar's Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County \_\_\_\_\_  
(c) City or town St. Louis 18  
(If outside city or town limits, write "RURAL")  
(d) Street No. 1642 S. Spring Ave  
(If rural, give location)  
(e) If foreign born, how long in U. S. A. \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 30th day October  
year 1940 hour 6:30 minute A. M.

21. I hereby certify that I attended the deceased from Jan 15  
1940 to Oct 30 1940  
that I last saw him alive on Oct 30 1940  
and that death occurred on the date and hour stated above.

Immediate cause of death Angina Pectoris Duration  
3 mos

Due to myocarditis

Due to \_\_\_\_\_  
Other conditions (Include pregnancy within 8 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_  
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 J. P. [Signature] (M. D. or other)  
Address 3833 Tuleman Date signed \_\_\_\_\_

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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**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 Paul J. Jones

Licensed Embalmer No. 2245

P. O. Address Salmon

**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.**