

S. No. 2  
M-5-4  
5-17-39  
PI X32876

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **22897**  
**6530**  
Registrar's No.

Registration District No. **318** Primary Registration District No. **1003**

1. PLACE OF DEATH:  
(a) County.....  
(b) City or town..... **St. Louis, Mo.**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: **4057 Maffitt**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution..... (Specify whether  
In this community..... (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo** (b) County..... **12**  
(c) City or town **St Louis.** **5 11**  
(If outside city or town limits, write "RURAL")  
(d) Street No. **4057 Maffitt Av.**  
(If rural, give location)  
(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country..... **0**

3. (a) PRINT FULL NAME **THOMAS CRINNION**

3. (b) If veteran, name war..... 3. (c) Social Security No.....

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

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

7. Birth date of deceased **Mar 16th 1868**  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
**75 4 3** hr. min.

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

10. Usual occupation **Clerk City water Wks**

11. Industry or business.....

12. Name **John Crinnion**

13. Birthplace **New York**  
(City, town, or county) (State or foreign country)

14. Maiden name **Catherine Hunt**

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

16. (a) Informant **Mrs Margaret Crinnion**

(b) Address **4057 Maffitt Ave.**

17. (a) **Burial** (b) Date thereof **July 22, 1943**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Calvary Cemetery**

18. (a) Signature of funeral director **Sullivan Bros.**

(b) Address **2849 N. Euclid Ave**

19. (a) **Jul 22 1943** (b) **J. F. Bradock**  
(Date received local registration) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **July** day **19th**  
year **1943** hour **2** minute **45** P. M.

21. I hereby certify that I attended the deceased from **Aug 8** 19**43** to **July 19** 19**43**  
that I last saw him alive on **July 19** 19**43**  
and that death occurred on the date and hour stated above

Immediate cause of death **Carcinoma of Prostate**

Due to **Chronic Atherosclerosis**

Due to.....  
Other conditions (Include pregnancy within 3 months of death) **51**

Major findings: Of operations.....  
Of autopsy.....

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

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

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) (c) Means of injury.....

23. Signature **W. N. White** (M. D. or other) **5 26 8**  
Address **2813 N. Kingshighway** Date signed **7-19-43**

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

MOTHER FATHER

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

Dr. White  
Kingshighway & Maffitt

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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.....

*Albert Mayfield*

Licensed Embalmer No.....

*3077*

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.**