

FILED JUN 30 1944

State File No. \_\_\_\_\_

5568

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

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

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County St. Louis, Mo.  
 (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:  
Homer G. Phillips Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 10 days  
(Specify whether  
 In this community 3 years 0  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Mad  
 (c) City or town St. Louis 21/19  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1827 Rear Carr St.  
(If rural, give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country 0

3. (a) PRINT FULL NAME Lena Crosby

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

4. Sex Female 5. Color or race Cal 6. (a) Single, widowed, married, divorced single

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

7. Birth date of deceased March 10 1915  
(Month) (Day) (Year)

8. AGE: Years 29 Months 3 Days 8 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation mile

11. Industry or business \_\_\_\_\_

12. Name Cliff Cole

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

14. Maiden name Miller Walker

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

16. (a) Informant J. Waller Brown  
 (b) Address 1827 Carr

17. (a) Burial (b) Date thereof 6 24 44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenwood

18. (a) Signature of funeral director Richardson  
 (b) Address 2625 S. Glasgow

19. (a) JUN 20 1944 J. F. Breck  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 18, year 1944 hour 3 minute 45 A. M.

21. I hereby certify that I attended the deceased from June 8, 1944, to June 18, 1944, that I last saw her alive on June 18, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Chr. Interstitial Nephritis with Uremia Duration 10 days

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

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 \_\_\_\_\_  
 (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. J. Griffin (M. D. or other) 6/19/44  
 Address Boonville Date signed \_\_\_\_\_

WRITE PLAINLY—USE UNFADING INK—PRINT FULL NAME

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 *A. P. Schuchman*  
Licensed Embalmer No. 2928  
P. O. Address *City*

**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.**