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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 22440

FILED JUL 15 1944

Registration District No. 3 Primary Registration District No. 6076 Registrar's No. 1475

1. PLACE OF DEATH:

(a) County St. Louis

(b) City or town Wellston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
6454 Wellsmar 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Louis 96

(c) City or town Wellston 0
(If outside city or town limits, write "RURAL")

(d) Street No. 6454 Wellsmar Ave., 0
(If rural, give location)

(e) Citizen of foreign country? ..... (Yes or No)

If yes, name country 0

3. (a) PRINT FULL NAME Carol Marie Cronin.

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife .....

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

7. Birth date of deceased July 11, 1942.
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
1	11	27	..... hr. ..... min.

9. Birthplace St. Louis, Mo. 0
(City, town, or county) (State or foreign country)

10. Usual occupation None

11. Industry or business .....

FATHER
12. Name Francis J. Cronin
13. Birthplace Unknown Missouri. 0
(City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Dorothy Sicking
15. Birthplace Unknown Missouri 0
(City, town, or county) (State or foreign country)

16. (a) Informant Francis J. Cronin.
(b) Address 6454 Wellsmar Ave.,

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof July 11/44.
(Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Jos. W. Clark
(b) Address 1125 Hodiamont Ave.,

19. (a) JUL 10 1944 (Date received local registrar) (b) C. G. McGavran, MD 75 (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 8
year 1944 hour 8.30 minute A.M. M.

21. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....;
that I last saw h..... alive on ....., 19....;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Leukemia	
Due to	
Due to 74a	
Other conditions (Include pregnancy within 3 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? ..... (Specify type of place)

While at work? ..... (e) Means of injury 0

23. Signature E. G. McGavran (M.D. or other) M.D.
Address St. Louis County Health Department Health Commissioner Date signed 7/10/44

(Licensed Embalmer's Statement on Reverse Side)

Dr. H.S.Breyfogle
Co. Hospital.

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 Alan J. Neely

Licensed Embalmer No. 3225

P. O. Address 1125 Hodiamont Ave.,

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.