

U. S. No. 2  
FORM-5-43  
Rev. 5-17-39  
I X3667

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 28727  
P. 1812  
Registrar's No. 1812

Registration District No. 317 Primary Registration District No. 3070

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

96  
2  
4

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:  
528 Holly Wood Pl.  
(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

3. (a) PRINT FULL NAME Margaret Crosbie

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

4. Sex Female 5. Color or race W 6. (a) Single, widowed, married, Divorced Widowed

6. (b) Name of husband or wife Thomas G. Crosbie 6. (c) Age of husband or wife if alive Deed years

7. Birth date of deceased Dec. 1st, 1866  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>77</u>	<u>8</u>	<u>27</u>	..... hr. .... min.

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

10. Usual occupation Housework

11. Industry or business.....

12. Name John Doyle

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

14. Maiden name Jane E. Haddon

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

16. (a) Informant Hazel McGunnele

(b) Address 538 Holly Wood Pl.

17. (a) Cremation (b) Date thereof 8-31-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Valhalla Crematory

18. (a) Signature of funeral director Provost Und. Co.

(b) Address 3710 N. Grand Blvd.

19. (a) AUG 30 1944 (b) C. G. McQuinn M.D.  
(Date received local health officer) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town Webster Groves  
(If outside city or town limits, write "RURAL")

(d) Street No. 538 Holly Wood Pl.  
(If rural, give location)

(e) Citizen of foreign country?..... (Yes or No)  
If yes, name country.....

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 28 day August  
year 1944 hour 3 minute 40 P.M.

21. I hereby certify that I attended the deceased from Feb. 15, 1943, to Aug. 28, 1944, that I last saw her alive on Aug. 28, 1944, and that death occurred on the date and hour stated above.

Immediate cause of death Chc. lymphatic leukemia Duration 10 yrs.

Due to.....

Due to.....

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?.....

While at work?..... (Specify type of place)

(e) Means of injury.....

23. Signature J. D. Stahl (M. D. or other) M.D.  
Address 104 W. Adams, Independence Mo. Date signed 8/28/44

**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 me

....., Registered Apprentice No.....  
working under my personal supervision.

Signed A. A. Smithers

Licensed Embalmer No. 3916

P. O. Address 3710 N. Grand Bl.

**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.**