No. 2
—2-43
5-17-39
X35697

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. 21382

FILED JUL 7 8 1946

Registration District No. _____ Primary Registration District No. 6076 Registrar's No. 1385

1. PLACE OF DEATH:
(a) County St. Louis
(b) City or town Manchester
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 4
Manchester Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether years, months or days)
In this community _____

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 000
(c) City or town St. Louis 17
(If outside city or town limits, write "RURAL")
(d) Street No. 4645 Pope Avenue 9
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Catherine Crosby
3. (b) If veteran, name war _____
3. (c) Social Security No. _____
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Marion
6. (c) Age of husband or wife if alive 92yrs years
7. Birth date of deceased August (Month) 1st. (Day) 1870 (Year)

8. AGE: Years 75 Months 10 Days 25 If less than one day _____ hr. _____ min.

9. Birthplace Illinois (City, town, or county) / (State or foreign country)
10. Usual occupation Housewife
11. Industry or business _____
12. Father Name James evelsizer
13. Father Birthplace Missouri (City, town, or county) (State or foreign country)
14. Mother Maiden name Virginia Cockrell
15. Mother Birthplace Virginia (City, town, or county) / (State or foreign country)
16. (a) Informant Harry Crosby
(b) Address 4645 Pope Avenue
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 29, 46 (Month) (Day) (Year)
(c) Place: burial or cremation St. Peters Cemetery
18. (a) Signature of funeral director Provost Moruary
(b) Address 3710 N. Grand Avenue
19. (a) 6-29-46 (Date received local registrar) (b) E. D. McDavan M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 26 year 1946 hour 720 minute A M.
21. I hereby certify that I attended the deceased from June 24, 1946, to June 26, 1946 that I last saw her alive on June 25, 1946 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Chr. Myocarditis	
Due to:	
Due to:	
Other conditions: Fracture rt. femur (Include pregnancy within 3 months of death)	2 days
Major findings: Of operations	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 _____
Signature C. O. Denny (M. D. or other) MD
Address Creve Coeur Mo. Date signed 6-27-46

(Licensed Embalmer's Statement on Reverse Side)

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 V E Morris

Licensed Embalmer No. 3360

P. O. Address.....

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

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

No. 2B
M—3-45
I X43880

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 317 Primary Registration District No. 6076 Registrar's No. 1388

1. PLACE OF DEATH:

(a) County St Louis

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

(c) Name of hospital or institution:
(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 (b) County

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

(d) Street No.
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Catherine Crosby

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex F

5. Color or race W

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

6. (b) Name of husband or wife

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

7. Birth date of deceased Aug 1 (Month) (Day) (Year)

8. AGE: Years 75 Months 10 Days If less than one day hr. min.

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

10. Usual occupation Accident occurred at

11. Industry or business home in moving pt.

FATHER
12. Name Date of accident from history
13. Birthplace June 23, 1946 (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant
(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation at home

18. (a) Signature of funeral director
(b) Address

19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June 26 year 1946 hour minute M.

21. I hereby certify that I attended the deceased from June 24, 1946, to June 26, 1946, that I last saw h. alive on June 25, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
The history is this pt had been an invalid bed pt. for 2 yrs. and the nite before she was sent to the Manchester Home, where I saw her for the first time. That her son in moving her had accidentally dropped. He did not know the leg was broken when she was brought out to the home which was the date of my first treatment.

Duration

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

23. Signature (M. D. or other)
Address Date signed

C H Denny M.D.

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION RECEIVED

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

20252

21382