

S. No. 2
M-5-43
v. 5-17-39
I X38671

State File No. _____

FILED JUN 20 1946

Registration District No. **318**

Primary Registration District No. **1003**

Registrar's No. **5145**

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Homer Phillip Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution one day
(Specify whether _____)

In this community 24 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO. (b) County St. Louis 5000

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

(d) Street No. 709 N. SARAH 1917
(If rural, give location) 9

(e) Citizen of foreign country? _____ (Yes or No) 0

If yes, name country _____

3. (a) PRINT FULL NAME MRS. FRANKIE CRAWFORD

3. (b) If veteran, name war NO.

3. (c) Social Security No. NONE

4. Sex F. 3 | 5. Color or race C

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

6. (b) Name of husband or wife HARRY

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased 5 6 1905
(Month) (Day) (Year)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 6 year 46 hour 3:45 minute 2 M.

21. I hereby certify that I attended the deceased from 5-3-46 to 6-6-46 1946
that I last saw him alive on 6-6-46 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Myocardial infarction - Insufficiency

Duration 8 mo.

Due to _____

Due to _____

Other conditions (include pregnancy within 3 months of death) 926

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

8. AGE: Years Months Days If less than one day

41 1 0 hr. min.

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

10. Usual occupation HOUSE WIFE

11. Industry or business 709 N. SARAH

MOTHER FATHER

12. Name Mrs. COMPT

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

14. Maiden name UNKNOWN

15. Birthplace UNKNOWN 0
(City, town, or county) (State or foreign country)

16. (a) Informant Harry Crawford 1
(b) Address 709 N. SARAH

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 6-10-46
(Month) (Day) (Year)

(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director Bernie Lane
(b) Address 3103 Washington Av.

19. (a) JUN 10 1946 J. F. Breda
(Date received local registrar) (Registrar's signature)

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 Dr. Edward Beel (M. D. or other) M.D.
Address 2901 Laclede Ave. Date signed 6-8-46

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

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..... *H. Claude Gordon*.....

Licensed Embalmer No. *3489*.....

P. O. Address *4575 Aldine*.....

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: