

No. 2
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED JAN 23 1947
318

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH
1003

2281
State File No. _____
Registrar's No. 187

Registration District No. _____ Primary Registration District No. _____

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

1. PLACE OF DEATH:
(a) County _____
(b) City or town **St. Louis, Missouri**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Christian Hospital 0
(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)

3. (a) PRINT FULL NAME **Daniel Webster Cruts**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **486-22-8944**

4. Sex **Male** 5. Color or race **White**
6. (a) Single, widowed, married, divorced **Divorced**
6. (b) Name of husband or wife **Eunice Cruts**
6. (c) Age of husband or wife if alive **54** years
7. Birth date of deceased **January 4 1887**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
59 0 2 hr. _____ min.

9. Birthplace **Bichy Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **Jacob Cruts**

13. Birthplace **Unknown New Jersey**
(City, town, or county) (State or foreign country)

14. Maiden name **Margaret Bailey**

15. Birthplace **Shelby Illinois**
(City, town, or county) (State or foreign country)

16. (a) Informant **Raney Cruts**

(b) Address **St. James, Missouri**

17. (a) **Burial** (b) Date thereof **1/9/47**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Masonic Cem-St. James, Mo**

18. (a) Signature of funeral director **Albert H. Hoppe, Inc.**

(b) Address **4700 Washington Blvd.**

19. (a) **JAN 7 1947** (Date received local registrar)

J. F. Breda (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County _____
(c) City or town **St. Louis**
(If outside city or town limits, write "RURAL")
(d) Street No. **1906 East Grand**
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Jan** day **6**
year **1947** hour **11** minute **47** A. M.

21. I hereby certify that I attended the deceased from **12-6-1946** to **1-6-1947**
and that I last saw him alive on **Jan 6 1947**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Rheumatic Heart Disease ?**

Due to **Rheumatic Arthritis**

Due to **Rt. Pleural Effusion**

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings: **None**
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 _____

Signature **Nicholas Vitale** (M. D. or other) **MD**

Address **3861 St Louis Ave.** Date signed **1/7/47**

PHYSICIAN
-Underline the cause to which death should be charged statistically.

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..... *R. W. Wilkinson*
Licensed Embalmer No. *3578*

P. O. Address.....

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.