. No. 2
—1/47
5-17-39

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

FEDERAL SECURITY AGENCY
National Office of Vital Statistics

FILED AUG 15 1947 318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 25431

Registration District No. ..... Primary Registration District No. 1003 Registrar's No. 7205

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: DePaul Hospital
(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 Missouri (b) County .....

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

(d) Street No. 4200a Clarence Avenue.
(If rural, give location)

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

If yes, name country .....

3. (a) PRINT FULL NAME Isabelle Mary Crosson

3. (b) If veteran, name war None

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 Milan Crosson

6. (c) Age of husband or wife if alive 38 years

7. Birth date of deceased June (Month) 8 (Day) 1909 (Year)

8. AGE:

Years	Months	Days	If less than one day
38	1	23	hr. ..... min.

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

10. Usual occupation Switchboard operator

11. Industry or business Southwestern Bell Telephone Co.

FATHER
12. Name William L. Stephenson
13. Birthplace Bunker Hill (City, town, or county) Illinois (State or foreign country)

MOTHER
14. Maiden name Virginia Draiemann
15. Birthplace Portage Des Sioux, Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Milan Crosson
(b) Address 4200a Clarence Avenue.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/4/47 (Month) (Day) (Year)
(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Albert H. Hoppe
(b) Address 4700 Washington Blvd.

19. (a) AUG 2 1947 (Date received local registrar) (b) J. F. Bredick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 31
year 1947 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from June 1, 1947 to July 31, 1947
that I last saw her alive on July 31, 1947
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of uterus. — Duration 24 yrs.

Due to .....

Due to .....

Other conditions .....
(Include pregnancy within 3 months of death)

Major findings:
Of operations .....

Of autopsy .....

PHYSICIAN
Underline the cause of 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? ..... Means of injury .....

23. Signature [signature] (M. D. or other)
Address 4114 W Florissant Date signed 8/1/47

Jefferson City Printing Co. (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 Henry M. Brammer

Licensed Embalmer No. 4200

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.