

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

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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 8 1948 318

THE STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH
1005

38009
State File No. _____
Registrar's No. 10417

Registration District No. _____ Primary Registration District No. _____

1. PLACE OF DEATH:
(a) County St. Louis, Mo
(b) City or town St. Louis, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
ST. LOUIS MATERNITY HOSPITAL
(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)

3. (a) PRINT FULL NAME INFANT CROSSWHITE
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced _____
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased NOVEMBER 19, 1948
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day hr. 15 min. _____

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name RILEY CROSSWHITE

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

14. Maiden name VIRGINIA LEE CASTLE

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

16. (a) Informant Maternity Hospital Records
(b) Address Anatomical Bureau 630 S. Kingshighway

17. (a) _____ (b) Date thereof NOV 30 1948
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Anatomical Bureau

18. (a) Signature of funeral director Rowland Mort. Service
(b) Address 4104 Manchester Ave
19. (a) NOV 30 1948 (b) J. B. Laster
(Date received local registrar) (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. 4580 ST. LOUIS AVENUE
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month NOVEMBER day 19th
year 1948 hour 5:30 P. minute _____ M. _____
21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him alive on November 19, 1948,
and that death occurred on the date and hour stated above.

Immediate cause of death congenital ht. disease Duration _____
Due to _____
Due to 151 _____
Other conditions prematurity
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy congenital ht. disease; tetralogy of fallot
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 John H. Carter (M. D. or other) M.D.
Address 630 S. Kingshighway Date signed _____

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.....

Licensed Embalmer No.....

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.