

FILED MAY 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

13686

State File No.

318

1003

Registrar's No. 3865

BIRTH NO. 49-024386 REG. DIST. NO. PRIMARY REG. DIST. NO.

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

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		c. LENGTH OF STAY (in this place) 1 day	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis		
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G. Phillips			d. STREET ADDRESS (If rural, give location) 2704 Delmar		
3. NAME OF DECEASED (Type or Print) (First) <i>Lura</i> (Middle) <i>Lee</i> (Last) <i>Crockett</i>		4. DATE OF DEATH (Month) (Day) (Year) 4 2 49			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH 4-2-49	9. AGE (in years last birthday) 1	IF UNDER 1 YEAR Months Days 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Missouri		12. CITIZEN OF WHAT COUNTRY?
13a. FATHER'S NAME		13b. MOTHER'S MAIDEN NAME Rosa Lee Crockett	14. NAME OF HUSBAND OR WIFE		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <i>Arthur M. Shuard</i> 2601 N. Whittier		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)					
MEDICAL CERTIFICATION					
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity					
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 159	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 77X	
22. I hereby certify that I attended the deceased from 4-1-1949, to 4-2-1949, that I last saw the deceased alive on 4-2-1949, and that death occurred at 3:05 p.m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <i>W. D. Simpson M.D.</i>			23b. ADDRESS 2601 N. Whittier		23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify)		24b. DATE APR 30 1949	24c. NAME OF CEMETERY OR CREMATORY Anatomical Bldg.		24d. LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG. APR 30 1949		REGISTRAR'S SIGNATURE <i>J. B. Passer</i>		25. FUNERAL DIRECTOR'S NAME AND ADDRESS Rowland Mortuary Service 4104 Manchester Ave.	

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.....

X..... Student Embalmer No.

working under my personal supervision.

Signed.....

Signed.....
Student Embalmer

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.