

FILED OCT 7 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31690

BIRTH NO. _____ REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 8178

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 town) OR TOWN St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis	
c. LENGTH OF STAY (in this place)		d. STREET ADDRESS (If rural, give location) 2734 Dickson St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Homer G Phillips Hospital			

3. NAME OF DECEASED (Type or Print) a. (First) Etta		b. (Middle)		c. (Last) Crosby		4. DATE OF DEATH (Month) (Day) (Year) Sept. 19 1949	
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed		8. DATE OF BIRTH May 15, 1892	
9. AGE (In years last birthday) 57		IF UNDER 1 YEAR Months		IF UNDER 4 HRS. Hours		IF UNDER 15 MIN. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Arkadelphia, Arkansas		12. CITIZEN OF WHAT COUNTRY? U.S.A.	

13a. FATHER'S NAME unknown		13b. MOTHER'S MAIDEN NAME unknown		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Gladys Becton, 2734 Dickson St.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Undet.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart Disease with Decompensation		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Right Pleural Effusion		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	

21a. ACCIDENT SUICIDE HOMICIDE (Specify) No		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 930	
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 H48X	

22. I hereby certify that I attended the deceased from 9-7, 19 49, to 9-19, 19 49, that I last saw the deceased alive on 9-19, 19 49, and that death occurred at 05p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) James J. Sedwick		23b. ADDRESS 2601 N Whittier St.		23c. DATE SIGNED 9-20-49	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 9-24-1949		24c. NAME OF CEMETERY OR CREMATORY Washington Park Cemetery	
				24d. LOCATION (City, town, or county) (State) St. Louis Missouri	

DATE REC'D BY LOCAL REG. SEP 22 1949		REGISTRAR'S SIGNATURE J.B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ellis Funeral Home, 2820 Stoddard St.	
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(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING 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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

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.