

FILED FEB 24 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

6111

State File No.

318

1003

1412

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

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) 3 1/2 WKS.

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis

d. FULL NAME OF HOSPITAL OR INSTITUTION Alexian Bros. Hosp.

d. STREET ADDRESS (If rural, give location) 3534 Halliday

3. NAME OF DECEASED (Type or Print) a. (First) Alexander b. (Middle) Crusius c. (Last) _____ 4. DATE OF DEATH (Month) (Day) (Year) 2 12 50

5. SEX M 6. COLOR OR RACE W 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) S 8. DATE OF BIRTH Aug. 4, 1869 9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months _____ Days _____ IF UNDER 1 HR. Hours _____ Min. _____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Druggist 10b. KIND OF BUSINESS OR INDUSTRY Retired 11. BIRTHPLACE (State or foreign country) Sauk City Wisconsin 12. CITIZEN OF WHAT COUNTRY? USA

13a. FATHER'S NAME Ludwig Crusius 13b. MOTHER'S MAIDEN NAME Emilia Schrom 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. None 17. INFORMANT'S SIGNATURE OR NAME Lina Crusius ADDRESS 3534 Halliday

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia 2 days

ANTECEDENT CAUSES DUE TO (b) Acute renal failure 2 days

DUE TO (c) Transurethral resection of prostate 3 days

II. OTHER SIGNIFICANT CONDITIONS Hypertrophied prostate over 2 mo.

19a. DATE OF OPERATION _____ 19b. MAJOR FINDINGS OF OPERATION Hypertrophied prostate 20. AUTOPSY? YES NO

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) 610X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ 21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK 21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from 22 Dec., 1949 to 12 Feb., 1950, that I last saw the deceased alive on 11 Feb., 1950, and that death occurred at 4:52A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Robert S. Nye, M.D. 23b. ADDRESS 3201 Arsenal St. 23c. DATE SIGNED 13 Feb. 50

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 2/14/50 24c. NAME OF CEMETERY OR CREMATORY Sunset Burial Park 24d. LOCATION (City, town, or county) (State) Affton, Mo.

DATE REC'D BY LOCAL REG. FEB 14 1950 REGISTRAR'S SIGNATURE J. B. Sauter 25. FUNERAL DIRECTOR'S SIGNATURE John L. Ziegenhein & Sons ADDRESS 7027 Gravois

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 W. G. Peterson

Licensed Embalmer No. 3767

P. O. Address 1027 Graven

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.