

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>100</b>		Registrar's No. <b>9739</b>	
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		<b>2159</b>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>3423 Klocke</b>				d. STREET ADDRESS (If rural, give location) <b>3423 Klocke</b>			
3. NAME OF DECEASED (Type or Print) <b>Bridget Crawford</b>			a. (First) <b>Crawford</b>			c. (Last)	
4. DATE OF DEATH <b>Nov. 1 1951</b>		(Month) (Day) (Year)		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widow</b>		8. DATE OF BIRTH <b>Dec. 23 1875</b>		9. AGE (In years last birthday) <b>75</b>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>St. Louis Mo.</b>		12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>John O. Donnell</b>		13b. MOTHER'S MAIDEN NAME <b>Mary Mogan</b>		14. NAME OF HUSBAND OR WIFE <b>John (Deceased)</b>			
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 <b>Mrs. Graf 3423 Klocke</b>			
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Myocardial Failure</b>  ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>Renal Disease</b>  II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Cholecystitis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b>  <b>6 mo.</b>	
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)			
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? <b>H42X</b>			
22. I hereby certify that I attended the deceased from <b>1 Oct 1951</b> to <b>1 Nov 1951</b> , that I last saw the deceased alive on <b>1 Nov 1951</b> , and that death occurred at <b>6:45P</b> m., from the causes and on the date stated above.							
23a. SIGNATURE <b>John J. Schumacher M.D.</b> (Degree or title)				23b. ADDRESS <b>4205 Virginia</b>		23c. DATE SIGNED <b>3/10/51</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24b. DATE <b>11-5-51</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		24d. LOCATION (City, town, or county) (State) <b>St Louis County Mo.</b>	
DATE REC'D BY LOCAL REG. <b>NOV 5 1951</b>		REGISTRAR'S SIGNATURE <b>J. Paul Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm. Schumacher 3013 Meramec</b>			

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

7-1-1947  
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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 \_\_\_\_\_

working under my personal supervision.

Student Embalmer No. ....

Signed.....

*Jack Haupt*

Signed.....  
Student Embalmer

Licensed Embalmer No. *4746*

P. O. Address *St. Louis, Mo.*

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.