

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43354

FILED JAN 10 1953

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1003

State File No.

11451

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 <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. LENGTH OF STAY (In this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		2029	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Jewish Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>6264 Gravois Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Cecelia</u>		a. (First)		b. (Middle) <u>Croissant</u>		c. (Last)	
4. DATE OF DEATH <u>12-11-1952</u>		(Month)		(Day)		(Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>		8. DATE OF BIRTH <u>7-21-1888</u>	
9. AGE (In years last birthday) <u>64</u>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 10 RES. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>William Hillshenstat</u>		13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>John J. Croissant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>John J. Croissant</u>		ADDRESS <u>6264 Gravois Ave</u>	
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) <u>Carcinoma of Stomach</u>		ANTECEDENT CAUSES DUE TO (b) <u>Carcinoma of Sigmoid Colon?</u> DUE TO (c) _____					
*This does not mean the mode of dying, such as heart failure, asphyxia, 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. <u>Arteriosclerotic heart disease? Congestive Heart Failure?</u>					
19a. DATE OF OPERATION <u>12/7/52</u>		19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Sigmoid - Metastases</u>				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? <u>153X</u>			
22. I hereby certify that I attended the deceased from <u>12/5</u> , 19 <u>52</u> , to <u>12/11</u> , 19 <u>52</u> ; that I last saw the deceased alive on <u>12/11</u> , 19 <u>52</u> , and that death occurred at <u>12:10 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE <u>Caron Hendin M.D.</u> (Degree or title)				23b. ADDRESS <u>457 No. Kings Highway</u>		23c. DATE SIGNED <u>12/12/52</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>12-13-1952</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Sunset Burial Park</u>		24d. LOCATION (City, town, or county) (State) <u>10160 Gravois Road Mo</u>	
DATE REC'D BY LOCAL REG. <u>DEC 12 1952</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ziegenheim Bros.</u>		ADDRESS <u>6409 Gravois Ave</u>	

(Licensed Embalmer's Placement on Reverse Side)

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

FO 6528

DR. HOLD IN 457 N. KINGSTON HIGHWAY

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.....

Law M. Squire

Signed.....

Student Embalmer

Licensed Embalmer No. *4343*

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.