

FILED JUN 10 1953

THE DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. _____

1953

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003

Registrar's No. 5324

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis, Missouri</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>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis City Hospital</u>		d. STREET ADDRESS <u>Ozanam Shelter</u>		2119	
3. NAME OF DECEASED (Type or Print)		a. (First)		b. (Middle)	
c. (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>WILLIAM</u>		<u>JOHN</u>		<u>CRABB</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	
8. DATE OF BIRTH <u>May 5, 1873</u>		9. AGE (In years last birthday)		10. MONTHS	
<u>80</u>		<u>80</u>		<u>80</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FACTORY WORKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Connecticut</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13a. FATHER'S NAME <u>William</u>		13b. MOTHER'S MAIDEN NAME <u>Anna Cain</u>	
14. NAME OF HUSBAND OR WIFE <u>ELLA COAKLIN.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>594-28-6242</u>	
17. INFORMANT'S SIGNATURE OR NAME <u>Hospital Record</u>		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <u>Carcinoma of the lung</u>		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. 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>163X</u>	
22. I hereby certify that I attended the deceased from <u>5-21-53</u> , 19 <u>53</u> , to <u>5-26-53</u> , 19 <u>53</u> , that I last saw the deceased alive on <u>5-26-53</u> , 19 <u>53</u> , and that death occurred at <u>7:30A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE <u>Malvin L. Fawcett, M.D.</u>		23b. ADDRESS <u>1515 Lafayette Avenue</u>		23c. DATE SIGNED <u>5-26-53</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24b. DATE <u>MAY-28-53</u>		24c. NAME OF CEMETERY OR CREMATORY <u>CALVARY</u>	
24d. LOCATION (City, town, or county) (State) <u>ST. LOUIS MO</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Earl Smith, M.D.</u>		ADDRESS <u>Conlan Kelly 4386 Fundell</u>	

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 *Frank C. Merrick*
Licensed Embalmer No. *4854*

P. O. Address *St. Louis 8, 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.