

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

45252

State File No. _____

FILED JAN 19 1954

318

1003

12130

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		Registrar's No. _____	
1. PLACE OF DEATH a. COUNTY <u>0</u>				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 town) <u>ST. LOUIS</u>		c. LENGTH OF STAY (in this place) _____		c. CITY (If outside corporate limits, write RURAL and give township) <u>ST. LOUIS</u>		2219	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>ST. JOHN'S HOSPITAL</u>				d. STREET ADDRESS (If rural, give location) <u>815 N 18th ST.</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>SALLIE</u>		b. (Middle) _____		c. (Last) <u>CRABTREE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>DEC. 22 1953</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>never married</u>		8. DATE OF BIRTH <u>6-17-1894</u>		9. AGE (in years last birthday) <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWS VENDOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13a. FATHER'S NAME <u>William F. Crabtree</u>			13b. MOTHER'S MAIDEN NAME <u>Anna Maria</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>Junious G. Crabtree - 913 Warren</u>			
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) <u>GENERALIZED PERITONITIS</u> ANTECEDENT CAUSES DUE TO (b) <u>PERFORATION SMALL INTESTINE</u> DUE TO (c) <u>LARGE BOWEL OBSTRUCTION</u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>4 DAYS?</u> <u>16 DAYS?</u>	
19a. DATE OF OPERATION <u>DEC. 11, 1953</u>		19b. MAJOR FINDINGS OF OPERATION <u>CONSTRUCTING LESION MIDSIGMOID</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) <u>ST. LOUIS MO.</u>			
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>5705</u>			
22. I hereby certify that I attended the deceased from <u>DEC. 9, 1953</u> , to <u>DEC. 22, 1953</u> , that I last saw the deceased alive on <u>DEC. 22, 1953</u> , and that death occurred at <u>10:30 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Paul W. Lammie M.D.</u>				23b. ADDRESS <u>4119 E. FARLIN AVE.</u>		23c. DATE SIGNED <u>DEC 23, 1953</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>12-26-1953</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Mt Pleasant Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Durham North Carolina</u>		
DATE REC'D BY LOCAL REG. <u>DEC 24 1953</u>		REGISTRAR'S SIGNATURE <u>J. Carl Smith M.D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Edw Koch + Son - 3516 E. 14th</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.....

Albert Mayfield

Licensed Embalmer No.

3077

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.