

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **2686**
Registrar's No. **0645**

FILED FEB 2 1954

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>St. Louis</u>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>20yrs</u>		e. STREET ADDRESS (If rural, give location) <u>2059</u> 5 <u>944 Maple Pl.</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>9444 Maple Pl.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Clarence</u>	b. (Middle) <u>Jack</u>	c. (Last) <u>Crockett</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 20, 1954</u>
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5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Jan. 19, 1881</u>	9. AGE (In years last birthday) <u>73</u>	10. UNDER 1 YEAR Months _____ Days _____	11. UNDER 1 MRS. Hours _____ Mins. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland Casualty Co.</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Granbury, Texas</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Ashley W. Crockett</u>	13b. MOTHER'S MAIDEN NAME <u>Onaldo Romance Haines</u>	14. NAME OF HUSBAND OR WIFE <u>Eunice E. Crockett</u>
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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>Mrs. C. J. Crockett</u>	ADDRESS <u>944 Maple Pl.</u>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Carcinoma of lung</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		
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 type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (m.)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>163X</u>
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22. I hereby certify that I attended the deceased from Oct 29, 1953, to Jan 20, 1954, that I last saw the deceased alive on Jan 19, 1954, and that death occurred at 3:07 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <u>Arthur B. Day M.D.</u>	23b. ADDRESS <u>3720 Washington</u>	23c. DATE SIGNED <u>1-21-54</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>Jan. 23, 1954</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis Mo.</u>
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DATE REC'D BY LOCAL REG. <u>JAN 21 1954</u>	REGISTRAR'S SIGNATURE <u>J. Earl Smith MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Gleason & Sons 6175 Delmar</u>	ADDRESS
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(Licensed Embalmer's Statement on Reverse Side)

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

Dr Anthony B. Day
3720 Washington
Ne 0870
till 1:30

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.....
Signature of Student Embalmer

Signed *jos. E. McCulloch*.....

Licensed Embalmer No. *24*.....

P. O. Address *6170*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.