

FILED JUN 24 1954

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

20350

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4788**

|   |   |  |   |
|---|---|--|---|
| 1. PLACE OF DEATH<br>a. COUNTY  |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE<br><b>Mo.</b><br>b. COUNTY<br><b>2079</b> |   |
| b. CITY (If outside corporate limits, write RURAL and give township)<br>OR TOWN<br><b>St. Louis 0</b> | c. LENGTH OF STAY (in this place)<br><b>26 Days</b> | c. CITY OR TOWN<br><b>St. Louis</b>  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Missouri Baptist Hospital</b>                           |   | e. STREET ADDRESS (If rural, give location)<br><b>4947 Theodore Ave.</b>   |   |

|   |                               |   |  |   |  |
|---|-------------------------------|---|--|---|--|
| 3. NAME OF DECEASED (Type or Print)<br>a. (First) <b>Raymond</b> b. (Middle) <b>B.</b> c. (Last) <b>Crowley</b> |                               |   | 4. DATE OF DEATH (Month) (Day) (Year)<br><b>May 28, 1954</b> |   |  |
| 5. SEX<br><b>M.</b>   | 6. COLOR OR RACE<br><b>W.</b> | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)<br><b>Single</b> | 8. DATE OF BIRTH<br><b>Nov. 4, 1895</b>                      |   | 9. AGE (In years last birthday) <b>58</b><br>If UNDER 1 YEAR: Months _____ Days _____<br>If UNDER 4 HRS.: Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerk</b>     |                               | 10b. KIND OF BUSINESS OR INDUSTRY<br><b>Wabash Railroad</b>             |  | 11. BIRTHPLACE (City and State or Foreign Country)<br><b>St. Louis, Mo. 0</b> |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.</b>   |                               |   |  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 13a. FATHER'S NAME<br><b>Francis F. Crowley</b>                                 |  | 13b. MOTHER'S MAIDEN NAME<br><b>Catherine Brooks</b> |  | 14. NAME OF HUSBAND OR WIFE<br><b>None</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)<br><b>No.</b> |  | 16. SOCIAL SECURITY NO.<br><b>No.</b>                |  | 17. INFORMANT'S SIGNATURE OR NAME ADDRESS<br><b>Francis D. Crowley 4947 Theodore</b> |  |

|  |   |                |   |
|--|---|----------------|---|
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | MEDICAL CERTIFICATION   |                | INTERVAL BETWEEN ONSET AND DEATH<br><br><b>3 months</b> |
|  | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Hypertrophy of Prostate</b>   |                |   |
|  | ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br><br>DUE TO (b) _____<br><br>DUE TO (c) _____ |                |   |
| II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death.<br><b>Myocarditis</b>  |   | <b>10 days</b> |   |

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>April 15/54</b>    |  | 19b. MAJOR FINDINGS OF OPERATION<br><b>Hypertrophy of Prostate (Transurethral Prostatic Resection)</b> |  | 20. AUTOPSY?<br>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?<br><b>177X</b>   |  |

22. I hereby certify that I attended the deceased from **May 2**, 19**54**, to **May 28**, 19**54**, that I last saw the deceased alive on **May 28**, 19**54**, and that death occurred at **0.20P.m.**, from the causes and on the date stated above.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 23a. SIGNATURE<br><b>Joseph E. Glenn</b>                  |  | (Degree or title)                          |  | 23b. ADDRESS<br><b>1958 Arcade Bldg.</b>                         |  | 23c. DATE SIGNED<br><b>May 29/54</b>                                   |  |
| 24a. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24b. DATE<br><b>June 1, 1954</b>           |  | 24c. NAME OF CEMETERY OR CREMATORY<br><b>Memorial Park Cemty</b> |  | 24d. LOCATION (City, town, or county) (State)<br><b>St. Louis, Mo.</b> |  |
| DATE REC'D BY LOCAL REG.<br><b>MAY 20 1954</b>            |  | REGISTRAR'S SIGNATURE<br><b>Carl Smith</b> |  | FUNERAL DIRECTOR'S SIGNATURE<br><b>Arthur J. Donnelly</b>        |  | ADDRESS<br><b>3840 Lindell Blvd</b>                                    |  |

(Licensed Embalmer's Statement on Reverse Side)

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

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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~~ me ..... Student Embalmer No. ....

working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed Wm. S. Sargent .....

Licensed Embalmer No. 46 .....

P. O. Address 1111 .....

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.