

FILED JAN 18 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **43516**REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **11432**

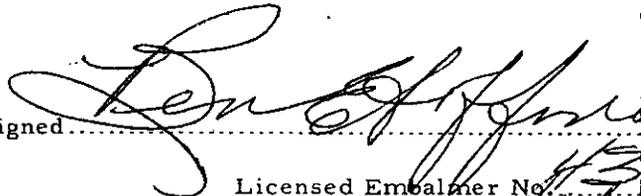
BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		Registrar's No. 11432	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE MISSOURI b. COUNTY LINCOLN			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo.		c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN TROY		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL				STREET ADDRESS (If rural, give location) 0570			
3. NAME OF DECEASED (Type or Print) a. (First) Opal			b. (Middle) NMN		c. (Last) Crouch		4. DATE OF DEATH (Month) (Day) (Year) Dec. 13/54
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH JULY 11-1913		9. AGE (In years last birthday) 41	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (City and State or Foreign Country) HAWKPOINT MA 0		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME PAAS		13b. MOTHER'S MAIDEN NAME LANSCHE		14. NAME OF HUSBAND OR WIFE BERTRUDE COLBERT EDWARD CROUCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) none		16. SOCIAL SECURITY NO. Unknown		17. INFORMANT'S SIGNATURE OR NAME Edward Crouch		ADDRESS Troy Mo	
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 I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Tumor, parietal lobe malignant ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
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"/>	
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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 193X			
22. I hereby certify that I attended the deceased from Dec. 11, 1954 , to Dec. 13, 1954 , that I last saw the deceased alive on Dec. 13, 1954 , and that death occurred at 3:40 p.m. from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) C. J. Villanar, M.D.				23b. ADDRESS BARNES HOSPITAL		23c. DATE SIGNED 12/13/54	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 12-16-54	24c. NAME OF CEMETERY OR CREMATORY Hawkpoint Cemetery		24d. LOCATION (City, town, or county) (State) Hawkpoint Ma		
DATE REC'D BY LOCAL REG. DEC 15 1954		REGISTRAR'S SIGNATURE J. Earl Smith M.D.		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Wayne McCoy Troy Mo			

S. P. (Licensed Embalmer's Statement on Reverse Side)

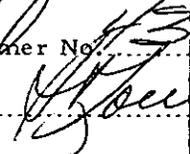
STATEMENT BY LICENSED EMBALMER

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.....


Licensed Embalmer No. 43

P. O. Address.....


Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (If 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.