

FILED MAY 13 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 13235  
3853

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

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Butler</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>St. Louis</u>		c. CITY OR TOWN <u>Fisk</u>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's</u>		STREET ADDRESS (If rural, give location) <u>RR # 1 0120</u>	

3. NAME OF DECEASED (Type or Print)			4. DATE OF DEATH		
a. (First) <u>Billie</u>	b. (Middle) <u>Sam</u>	c. (Last) <u>Crowford</u>	(Month) <u>4</u>	(Day) <u>29</u>	(Year) <u>55</u>

5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4-26-1942</u>	9. AGE (In years last birthday) <u>13</u>	IF UNDER 1 YEAR Months <u>3</u>	IF UNDER 24 HRS. Days Hours Min.
-----------------	---------------------------	--	-----------------------------------	---	---------------------------------	----------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <u>Barnie Mo.</u>	12. CITIZEN OF WHAT COUNTRY?
---	-----------------------------------	--	------------------------------

13a. FATHER'S NAME <u>Clyde W. Crawford</u>	13b. MOTHER'S MAIDEN NAME <u>Isabelle Stokes</u>	14. NAME OF HUSBAND OR WIFE <u>L</u>
---	--	--------------------------------------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)   (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME <u>HE Braun</u>	ADDRESS <u>500 S. Kingshighway</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, asthenia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Increased Intracranial Pressure</u>		
	ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <u>Tuberculous sclerosis</u> 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 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? <u>7531</u>
--	--	--

22. I hereby certify that I attended the deceased from 4-1-1955, to 4-29-1955, that I last saw the deceased alive on 4-29-1955, and that death occurred at 1:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE <u>Dr. L. H. Smith</u> (Degree or title)	23b. ADDRESS <u>500 South Kingshighway</u>	23c. DATE SIGNED <u>4-29-55</u>
---	--	---------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>4-30-55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Local</u>	24d. LOCATION (City, town, or county) (State) <u>Dexter Mo</u>
--	--------------------------	---	--

DATE REC'D BY LOCAL REG. <u>APR 30 1955</u>	REGISTRAR'S SIGNATURE <u>J. Carl Smith</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Albert H. Hoppe</u>	ADDRESS <u>4700 Washington</u>
---	--	---	--------------------------------

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

MAY 1.

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 *John J. Haines*  
Licensed Embalmer No. *410*  
P. O. Address *H. H. Haines*

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.