

FILED AUG 15 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. **6389**

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

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place)		d. STREET ADDRESS (If rural, give location) 18 3229 LaSalle St.	
d. FULL NAME OF HOSPITAL OR INSTITUTION HOME 3229 LaSalle			

3. NAME OF DECEASED (Type or Print) Elizabeth Craven			4. DATE OF DEATH (Month) (Day) (Year) 7-23-55		
5. SEX Female		6. COLOR OR RACE Col.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		8. DATE OF BIRTH Apr. 6, 1866	
9. AGE (In years less birthday) 89		11. BIRTHPLACE (State or foreign country) St. Charles, Mo.		12. CITIZEN OF WHAT COUNTRY? USA	

13a. FATHER'S NAME Daniel Thomas		13b. MOTHER'S MAIDEN NAME Seison		14. NAME OF HUSBAND OR WIFE Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT'S SIGNATURE OR NAME Mrs. Ruffin	
				ADDRESS 3229 LaSalle	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* Hypertensive Cardio-Vascular Disease		ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. None			DUE TO (b) ?
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.		DUE TO (c)			1
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION 7/15		19b. MAJOR FINDINGS OF OPERATION 7/15		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) 443X	
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?	

22. I hereby certify that I attended the deceased from **7/15, 1955** to **7/23, 1955** that I last saw the deceased alive on **7/23, 1955** and that death occurred at **10:30 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE [Signature]		23b. ADDRESS 3136 Cherokee		23c. DATE SIGNED 7/23/55	
24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		24b. DATE 7-26-1955		24c. NAME OF CEMETERY OR CREMATORY Washington Park	
				24d. LOCATION (City, town, or county) (State) 5500 Brown Rd. St. Louis Co.	

DATE REC'D BY LOCAL REG. JUL 25 1955		REGISTRAR'S SIGNATURE J. Earl Smith, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Gen. H. Bruce	
				ADDRESS 446 Washington	

MAY 28 1928

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.....

working under my personal supervision.

Student Embalmer No.....

Signed.....

Frederick P. Starks

Signed.....
Student Embalmer

Licensed Embalmer No. *4599*

P. O. Address *St. Louis*

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.