

FILED NOV 10 1955

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. **35342**BIRTH NO. _____ REG. DIST. NO. **317** PRIMARY REG. DIST. NO. **541** Registrar's No. **2383**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Clayton		c. CITY OR TOWN Overland 423	
c. LENGTH OF STAY (In this place) D.O.A.		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 St. Louis County Hospital		f. STREET ADDRESS (If rural, give location) 2426 Gass Avenue	

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Coleman c. (Last) Croson			4. DATE OF DEATH (Month) (Day) (Year) Oct. 16, 1955		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married	8. DATE OF BIRTH Mar. 15, 1895	9. AGE (In years last birthday) 60	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Contracting	11. BIRTHPLACE (City and State or Foreign Country) Chamberlain, So. Dak.		12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Charles F. Croson	13b. MOTHER'S MAIDEN NAME Julia McConnell	14. NAME OF HUSBAND OR WIFE Mabel Croson
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) No	17. INFORMANT'S SIGNATURE OR NAME Mabel Croson	ADDRESS 2426-Gass Av-Overland
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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, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH Immediate 1955 19 Aug 1955
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial failure		
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Chronic myocarditis DUE TO (c) Coronary heart disease		
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) 4201
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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? _____
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22. I hereby certify that I attended the deceased from **4 Oct**, 19**55**, to **11 Oct**, 19**55**, that I last saw the deceased alive on **11 Oct**, 19**55**, and that death occurred at **1:00 P** m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Paul R. Whitener M.D.	23b. ADDRESS 2403 Brown St. Louis 14 Mo	23c. DATE SIGNED 17 Oct 55
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24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 10-19-1955	24c. NAME OF CEMETERY OR CREMATORY Memorial Park	24d. LOCATION (City, town, or county) (State) Normandy Mo.
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DATE REC'D BY LOCAL REG. 10-19-55	REGISTRAR'S SIGNATURE Herbert R. Domb MD	25. FUNERAL DIRECTOR'S SIGNATURE Blumenthal 1508 Mo.	ADDRESS 2504-Woodson Rd-Overland-14-Mo.
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(Licensed Embalmer's Statement on Reverse Side)

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

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 *Oscar F. Mueller*

Licensed Embalmer No. *303*

P. O. Address *Overland*

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.