

FILED JAN 6 1956

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

41947

State File No.

318

1003

10709

BIRTH NO. _____ REG. DIST. NO. _____ PRIMARY REG. DIST. NO. _____ Registrar's No. _____

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN		b. COUNTY	
c. LENGTH OF STAY (In this place)		c. CITY OR TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	

1. PLACE OF DEATH: a. COUNTY: **St. Louis Mo**
2. USUAL RESIDENCE: a. STATE: **Ill.** b. COUNTY: **Madison**
c. CITY OR TOWN: **Collinsville**
d. FULL NAME OF HOSPITAL OR INSTITUTION: **BARNES HOSPITAL**
c. LENGTH OF STAY: **10 days**
c. CITY OR TOWN: **Collinsville**
d. FULL NAME OF HOSPITAL OR INSTITUTION: **BARNES HOSPITAL**
d. Is Residence within limits of a city or incorporated town? Yes No

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
a. (First)	b. (Middle)	c. (Last)	(Month) (Day) (Year)
5. SEX		6. COLOR OR RACE	
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Use 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)		12. CITIZEN OF WHAT COUNTRY?	

3. NAME OF DECEASED: a. (First) **Woodrow** b. (Middle) **JAMES** c. (Last) **CRUMER**
4. DATE OF DEATH: **12-4-55**
5. SEX: **Male**
6. COLOR OR RACE: **Negro**
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED: **Married**
8. DATE OF BIRTH: **MAY 14, 1918**
10a. USUAL OCCUPATION: **LABORER**
10b. KIND OF BUSINESS OR INDUSTRY: **SWIFT Pkng Co**
11. BIRTHPLACE: **OFallon, Ill.**
12. CITIZEN OF WHAT COUNTRY?: **U.S.A**

13a. FATHER'S NAME	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
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 ADDRESS

13a. FATHER'S NAME: **Edward Crumer**
13b. MOTHER'S MAIDEN NAME: **Mamie Brooks**
14. NAME OF HUSBAND OR WIFE: **Annabelle**
15. WAS DECEASED EVER IN U.S. ARMED FORCES? **No**
16. SOCIAL SECURITY NO.: _____
17. INFORMANT'S SIGNATURE OR NAME ADDRESS: **Mamie Crumer 214 Mulberry Collinsville, Ill**

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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 6 MO.
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		
	ANTECEDENT CAUSES		15-20 yrs.
	DUE TO (b)		
	DUE TO (c)		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

18. CAUSE OF DEATH: I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) **Malignant hypertension**
ANTECEDENT CAUSES: **Chronic Nephrosclerosis**
DUE TO (b): _____
DUE TO (c): _____
II. OTHER SIGNIFICANT CONDITIONS: _____
INTERVAL BETWEEN ONSET AND DEATH: **6 MO.**
15-20 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" 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)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

19a. DATE OF OPERATION: _____
19b. MAJOR FINDINGS OF OPERATION: **446 x**
20. AUTOPSY? YES NO
21a. ACCIDENT, SUICIDE, HOMICIDE: _____
21b. PLACE OF INJURY: _____
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): _____
21d. TIME OF INJURY: _____
21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK
21f. HOW DID INJURY OCCUR?: _____

22. I hereby certify that I attended the deceased from **11-25, 1955** to **12-4, 1955**, that I last saw the deceased alive on **12-4, 1955**, and that death occurred at **3:45 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	

23a. SIGNATURE: **F.R. Bradley** (Degree or title) **M.D.**
23b. ADDRESS: **BARNES HOSPITAL**
23c. DATE SIGNED: **12/4/55**
24a. BURIAL, CREMATION, REMOVAL: **Reinment**
24b. DATE: **12-9-55**
24c. NAME OF CEMETERY OR CREMATORY: **College Hill**
24d. LOCATION: **Lebanon Ill.**
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: **Carl Smith M.R.M.C. Green 4060 Washington**

DATE REC'D BY LOCAL REG. **DEC 7 1955**
REGISTRAR'S SIGNATURE _____
(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING 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 *Melvin C. Green*.....

Licensed Embalmer No. *44*.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.