

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED MAY 25 1956

State File No. **17726**
Registrar's No. **4430**

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. CITY OR TOWN St. Louis	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 DePaul Hospital		e. STREET ADDRESS (If rural, give location) 5989 North Pointe	

3. NAME OF DECEASED (Type or Print)	a. (First) Joseph	b. (Middle) A.	c. (Last) Crook	4. DATE OF DEATH (Month) (Day) (Year) May 7 1956
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5. SEX male	6. COLOR OR RACE white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH Dec. 21 1900	9. AGE (In years) (Month) (Day) (Year) 55
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired	10b. KIND OF BUSINESS OR INDUSTRY Pullman Co.	11. BIRTHPLACE (City and State or Foreign Country) Illinois	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13a. FATHER'S NAME William E. Crook	13b. MOTHER'S MAIDEN NAME Mary Sullivan	14. NAME OF HUSBAND OR WIFE Bertha Crook
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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.	17. INFORMANT'S SIGNATURE OR NAME Bertha Crook	ADDRESS 5989 North Pointe
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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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH 2 wks
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Failure		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. Rheumatic 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 416x	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)
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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 **Oct. 1, 1950**, to **May 7, 1956**, that I last saw the deceased alive on **May 6, 1956**, and that death occurred at **2:20 a.m.**, from the causes and on the date stated above.

23a. SIGNATURE D.P. Moran	(Degree or title) M.D.	23b. ADDRESS 539 N. Grand St. St. Louis	23c. DATE SIGNED 5/7/56
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 5/9/56	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	24d. LOCATION (City, town, or county) (State) St. Louis County Mo
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DATE REC'D BY LOCAL REG. MAY 7 1956	REGISTRAR'S SIGNATURE Charles Smith	25. FUNERAL DIRECTOR'S SIGNATURE Buchholz Mortuary	ADDRESS 5967 W. Florissant
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

m & B. (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 *W. J. Buchholz*
Licensed Embalmer No.

P. O. Address

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.