FILED JAN 25 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER 2634

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 133

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI — Inside Limits Yes ☐ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSPITAL # 1. — Length of stay in 15 239 — 25

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MISSOURI b. COUNTY
c. CITY OR TOWN ST. LOUIS — Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location) 2715 SHENAGOAH — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First HERBERT Middle DELOIS Last CROSS
4. DATE OF DEATH Month Day Year JAN 4, 1957
5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 12-27-87
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WINDOW CLEANER
10b. KIND OF BUSINESS OR INDUSTRY STD. WINDOW CL.
11. BIRTHPLACE (City and state or country) MICHIGAN
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILSON CROSS
14. MOTHER'S MAIDEN NAME UNK
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 487-26-4189
17. INFORMANT EDITH LEITZ Address 2715 SHENAGOAH

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rt. Lower Lobe Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) ____ DUE TO (c) ____
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 493x
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 12/27/56, to 1/4/57 and last saw her/him alive on 1/4/57
Death occurred at 12:20 P.M m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Quentin C. Cox M. D.
22b. ADDRESS 1515 LAFAYETTE AVE.
22c. DATE SIGNED 1/7/57

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
23b. DATE JAN 7 1957
23c. NAME OF CEMETERY OR CREMATORY MEMORIAL PARK
23d. LOCATION (City, town, or county) ST LOUIS Co (State) Mo

24. FUNERAL DIRECTOR Thomas Kutz ADDRESS 2706 Gravois
25. DATE RECD. BY LOCAL REG. JAN 7 1957
26. REGISTRAR'S SIGNATURE J Earl Smith MD MKB

(Licensed Embalmer's Statement on Reverse Side)

Health, Welfare Public Service

300 0
1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was em

by me, or by ....., Student Embalmer No.....

working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed Leo J. Budde

Licensed Embalmer No. 39

P. O. Address St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (
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.