

Health,
& Welfare
Public
Service

S. 300
v. 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. Securing the medical certification in the specific manner required by 1933-1934 laws.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

14582

STATE FILE NUMBER

FILED MAY 6 - 1957

Registration District No.

318

Primary Registration District No.

1003

Registrar's

3714

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 37 Hamilton Medical Center.			Length of stay in lb 2 mo.		STREET ADDRESS 9518 5960 Clemens Ave		(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES S CRIM.				4. DATE OF DEATH Month Day Year April 18, 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1870		9. AGE (In years last birthday) 86	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Banker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) Gallion, Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME C.S. Crim				14. MOTHER'S MAIDEN NAME Martha (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 Address Mrs. J. A. Thompson 5960 Clemens Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrhythmia</i> DUE TO (b) <i>Arteriosclerotic Heart Dis.</i> DUE TO (c) <i>Pulmonary Emphysema</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>420.0</i>							INTERVAL BETWEEN ONSET AND DEATH <i>1 hr</i> <i>10 yrs.</i>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		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 <i>1955</i> , to <i>Present</i> and last saw <i>him</i> alive on <i>4-17-57</i> Death occurred at <i>2:10 A.M.</i> m on the date stated above; and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) <i>W. F. Keenan, M.D.</i>				22b. ADDRESS <i>634 N. Grand</i>		22c. DATE SIGNED <i>4-18-57</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>4-19-47</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fairview Cemetery</i>		23d. LOCATION (City, town, or county) (State) <i>Gallion, Ohio.</i>		
24. FUNERAL DIRECTOR ADDRESS <i>C.R. Lupton & Sons; 7233 Delmar</i>			25. DATE RECD. BY LOCAL REG. <i>APR 18 57</i>		26. REGISTRAR'S SIGNATURE <i>J. Carl Smith M.D.</i>		

(Licensed Embalmer's Statement on Reverse Side)

FR-1-5754

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 *Arnold W. Schoene*

Licensed Embalmer No. *386*

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.