

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

25208

FILED NUMBER

FILED JUL 23 1957

Registration District No. 170 Primary Registration District No. 5632 Registrar's No. 114

300
1-57

1. PLACE OF DEATH a. COUNTY <u>Laclede</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Rural Osage T.S.</u>		c. CITY OR TOWN <u>St. Louis, Mo.</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>9 Miles E. 06</u>		d. STREET ADDRESS <u>5136 Delmar</u>	

3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>H.</u> Last <u>CROCKER</u>			4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1957</u>		
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5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1874</u>	9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Resturant Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Food</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Mo.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>John H. Crocker</u>	13b. MOTHER'S MAIDEN NAME <u>Sara J. Gowan</u>	14. NAME OF HUSBAND OR WIFE <u>Nina June Crocker</u>
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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) <u>No.</u>	16. SOCIAL SECURITY NO. <u>486-18-0575</u>	17. INFORMANT <u>Mrs/ Walter Noss</u> Address <u>Springfield, Mo.</u>
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull - Crushed Chest</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Imm</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) _____	
	DUE TO (c) _____	

PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Fractured leg and arm facial lacerations</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT <input checked="" 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.) <u>Automobile collision</u>
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20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <u>8:00 P.M.</u>	20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Highway 88</u>	20f. CITY, TOWN, OR LOCATION <u>Lebanon,</u>	COUNTY <u>Laclede</u>	STATE <u>Missouri</u>
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21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at <u>8:00 P</u> m on the date stated above; and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <u>Stanley R Palmer</u> (Print name or title)	22b. ADDRESS <u>Lebanon, Mo.</u>	22c. DATE SIGNED <u>7/17/57</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>7/17/57</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>St. Louis, Mo.</u>
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24. FUNERAL DIRECTOR <u>Holman Funeral Home</u> ADDRESS <u>Lebanon, Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>7-17-1957</u>	26. REGISTRAR'S SIGNATURE <u>Hella L. Hays</u>
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Local, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

MEDICAL CERTIFICATION

JUL 19 1962

AUG 2 1957

AUG 12 1957

JUL 29 1957

Received 7-22-57
Laclede County Health Unit
File No. 114
Date Filed 7-22-57

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 Deisey M. Howe

Licensed Embalmer No. 4272
P. O. Address Lebanon, Mo.

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.