

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED JUL 23 1957

STATE FILE NUMBER

Registration District No. 170 Primary Registration District No. 5632 Registrar's No. 113

300  
-57

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE  
MEDICAL CERTIFICATION

Doctor, coroner, etc. must use only statements  
All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <b>Laclede</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Illinois</b> b. COUNTY <b>Cook</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>RURAL Osage T.S.</b>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	c. CITY OR TOWN <b>Chicago</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>9 miles East 66</b>		Length of stay in lb -	d. STREET ADDRESS (If outside, give location) <b>1014 Marquette Rd.</b>
3. NAME OF DECEASED (Type or print) <b>FRANK</b>		First <b>H.</b> Middle <b>CROCKER.</b> Last	4. DATE OF DEATH Month <b>July</b> Day <b>16,</b> Year <b>1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1881</b>
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Bank Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Finance.</b>	9. AGE (In years) <b>75</b> (If birthday) IF UNDER 1 YEAR: Months <b>7</b> Days <b>15</b> Hours <b>15</b> Min.
11. BIRTHPLACE (City and state or country) <b>St. Louis, Mo.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>John H. Crocker</b>		13b. MOTHER'S MAIDEN NAME <b>Sara J. Gowan</b>	14. NAME OF HUSBAND OR WIFE <b>MARYAN Crocker</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> , No <input type="checkbox"/> , or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>335-12-7940</b>	17. INFORMANT <b>Mrs. Walter Noss</b> Address <b>Springfield, Mo.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull Crushed Chest</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Imm.</b>
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) <b>Fractured left arm facial lacerations</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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.) <b>Automobile collision</b>	
20c. TIME OF INJURY Hour <b>8:00</b> a.m. <b>P.M.</b> Month, Day, Year <b>7 16 57</b>			
20d. INJURY OCCURRED WHILE AT WORK <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.) <b>highway 66</b>	20f. CITY, TOWN, OR LOCATION <b>Lebanon</b> COUNTY <b>Laclede</b> STATE <b>Mo.</b>
21. I attended the deceased from _____ to _____ and last saw her/him alive on _____ Death occurred at <b>8:00 P.M.</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>Stanley R. Palmer</i> (Degree or title)		22b. ADDRESS <i>Lebanon, Mo.</i>	22c. DATE SIGNED <b>7/17/57</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	23b. DATE <b>7/17/57</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>
24. FUNERAL DIRECTOR <b>Palmer Funeral Home</b> ADDRESS <b>Lebanon, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>7-17-1957</b>	26. REGISTRAR'S SIGNATURE <i>Wella L. May</i>

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Received 7-22-57  
Laclede County Health Unit  
File No. 113  
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 Stanley R. Pabner

Licensed Embalmer No. 4810  
P. O. Address Delaware, 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.