

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38700

State File No. _____

FILED OCT 18 1957

BIRTH NO. _____ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 2380

1. PLACE OF DEATH
a. COUNTY St Louis

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Mo. b. COUNTY St Louis

b. CITY (If outside corporate limits, write RURAL and give township) Koch c. LENGTH OF STAY (in this place) 7 days

c. CITY OR TOWN St Louis d. Is Residence within limits of a city or incorporated town? Yes No

d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION 29 Robert Koch Hospital

e. STREET ADDRESS (If rural, give location) 3001 a Thomas

3. NAME OF DECEASED (Type or Print) a. (First) Nona b. (Middle) Sarah c. (Last) Cranshaw

4. DATE OF DEATH (Month) (Day) (Year) Sept 24 1957

5. SEX F

6. COLOR OR RACE C

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED

8. DATE OF BIRTH 08-4-12

9. AGE (In years) (Month) (Day) (Hour) (Min.) 45 1 1 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nil

10b. KIND OF BUSINESS OR INDUSTRY HOME

11. BIRTHPLACE (City and State or Foreign Country) St Louis, Mo.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13a. FATHER'S NAME Eugene Cranshaw

13b. MOTHER'S MAIDEN NAME Elizabeth Cranshaw

14. NAME OF HUSBAND OR WIFE _____

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO

16. SOCIAL SECURITY NO. NO

17. INFORMANT'S SIGNATURE OR NAME AND ADDRESS Eugene Green 2814 Mill St

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
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) chronic pulmonary tuberculosis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) _____
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic alcoholism

INTERVAL BETWEEN ONSET AND DEATH 3

19a. DATE OF OPERATION _____

19b. MAJOR FINDINGS OF OPERATION _____

20. AUTOPSY? 2
YES NO

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) 002X

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____

21e. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK

21f. HOW DID INJURY OCCUR? _____

22. I hereby certify that I attended the deceased from Sept 17, 1957, to Sept 24, 1957, that I last saw the deceased alive on Sept 24, 1957, and that death occurred at 6:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Bernard Friedman, M.D.

23b. ADDRESS Koch 22 Mo. 23c. DATE SIGNED 9-25-57

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Sept 30/57

24c. NAME OF CEMETERY OR CREMATORY Oak Dale Cem

24d. LOCATION (City, town, or county) (State) St Louis MO

DATE REC'D BY LOCAL REG. 9-26-57

REGISTRAR'S SIGNATURE Herbert R. Donohue, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS T. A. Green 214 Delmar

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *F. A. Sullivan*

Licensed Embalmer No. *2963*

P. O. Address *4214 Delmar*

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.