

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002412
STATE FILE NUMBER

Health,
Welfare
Public
Service

300
-57
5

FILED JAN 28 1959 Registration District No. 276 Primary Registration District No. 441D Registrar's No. 74

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Phelps</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO.</u> b. COUNTY <u>ST. LOUIS</u> | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>ST. JAMES</u> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Soldiers Home</u> | | Length of stay in 1b <u>2 yrs</u> | 2007 STREET ADDRESS (If outside, give location) <u>0</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>CRATTEY</u> Last <u>CRATTEY</u> | | | 4. DATE OF DEATH Month <u>1</u> Day <u>17</u> Year <u>59</u> |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-27-1879</u> |
| 9. AGE (In years last birthday) <u>79</u> | | IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>-</u> | 11. BIRTHPLACE (City and state or country) <u>Nov. 27, 1879 - MO.</u> |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 13a. FATHER'S NAME <u>Do Not Know</u> | |
| 13b. MOTHER'S MAIDEN NAME <u>Do Not Know</u> | | 14. NAME OF HUSBAND OR WIFE <u>None</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u> | | 16. SOCIAL SECURITY NO. <u>-</u> | 17. INFORMANT Address <u>Soldiers Home Office - ST. JAMES, MO.</u> |
| 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>Congestive Heart Failure</u> <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>-</u> DUE TO (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>4500</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <u>2</u> |
| 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 <u>-</u> Month, Day, Year a.m. <u>-</u> p.m. <u>-</u> | | 20d. INJURY OCCURRED WHILE AT <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 <u>Oct 24, 1956</u> to <u>Jan 17, 59</u> and last saw him <u>live on Jan 16, 59</u> . Death occurred at <u>4:35</u> <u>PM</u> on the date stated above and to the best of my knowledge, from the causes stated. | | | |
| 21a. SIGNATURE <u>Ruth B. Powell M.D.</u> (Degree or title) | | 21b. ADDRESS <u>St. James, Mo</u> | |
| 21c. DATE SIGNED <u>1-17-59</u> | | 22. DATE SIGNED | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <u>Burial</u> | | 23b. DATE <u>1-19-59</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cem.</u> | | 23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS, MO.</u> | |
| 24. FUNERAL DIRECTOR <u>Stegman & Son - St. James, Mo.</u> | | 25. DATE RECD. BY LOCAL REG. <u>1-24-1959</u> | |
| 26. REGISTRAR'S SIGNATURE <u>Ruth B. Powell</u> | | 26. REGISTRAR'S SIGNATURE | |

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

JAN 29 1959

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 *me*, Student Embalmer No. working under my personal supervision.

Student
Signature of Student Embalmer

Signed *Oral E. Tucker*

Licensed Embalmer No. *3544*
P. O. Address. *St James 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. ..