

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-002845
STATE FILE NUMBER

FILED FEB 10 1959

Registration District No. _____ Primary Registration District No. _____ Registrar's No. **488**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair			
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 East St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Inf.		Length of stay in lb 1wk		d. STREET ADDRESS 2119-A Kansas (If outside, give location)	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle _____ Last CROON			4. DATE OF DEATH Month January Day 12 Year 1959		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1921	9. AGE (In years last birthday) 37	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework	10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) East St. Louis, Ill.		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME ROBERT CROON		13b. MOTHER'S MAIDEN NAME MOZELLA PETTIES		14. NAME OF HUSBAND OR WIFE NONE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Dorothy Miller, E. St. Louis, Ill. Address: 2128 Illinois		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO (b) Malignant hypertension DUE TO (c) Chronic Glomerular Nephritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 445X					INTERVAL BETWEEN ONSET AND DEATH 2 weeks unknown unknown
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 <input type="checkbox"/> NOT WHILE 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 March 1956 to Jan 1959 and last saw her alive on 1/11/59 Death occurred at 7:30 p.m. on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE Chas R. Taylor, M.D. (Degree or title)			22b. ADDRESS 1401 Gaty		22c. DATE SIGNED 1/14/59
23a. BURIAL, CREMATION, RECVL (Specify)	23b. DATE 1/18/59	23c. NAME OF CEMETERY OR CREMATORY Booker Washington		23d. LOCATION (City, town, or county) (State) Centreville Township, Ill.	
24. FUNERAL DIRECTOR Monroe E. Offner		ADDRESS 2114 Mo. Ave. E. St. Louis, Ill.		DATE RECD. BY LOCAL REG. JAN 15 '59	26. REGISTRAR'S SIGNATURE Charles Smith M.D. acm

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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number, surname, etc. must use only standard nomenclature if item 10. no symptoms will be listed.

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 *Frank Proko pf*

Licensed Embalmer No. *4356*

P. O. Address *St. Louis, 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.