

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019071  
State File No.

2 5069  
Registrar's No.

FILED JUN 4 1959

|  |  |   |   |  |  |  |  |
|--|--|---|---|--|--|--|--|
| BIRTH NO. _____  |  | REG. DIST. NO. _____  |   | PRIMARY REG. DIST. NO. _____   |  | Registrar's No. <b>2 5069</b>  |  |
| 1. PLACE OF DEATH<br>a. COUNTY _____   |  |   |   | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).<br>a. STATE <b>MISSOURI</b> b. COUNTY _____ |  |  |  |
| b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>  |  | c. LENGTH OF STAY (in this place) _____   |   | c. CITY OR TOWN <b>St. Louis 20</b>  |  | d. Is Residence within limits of a city or incorporated town?<br>Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> |  |
| d. FULL NAME OF HOSPITAL OR INSTITUTION <b>De Paul Hospital</b>  |  |   |   | e. STREET ADDRESS (If rural, give location) <b>5986 Theodore</b>   |  |  |  |
| 3. NAME OF DECEASED<br>(Type or Print) a. (First) <b>Lawrence</b>  |  | b. (Middle) <b>D.</b>   |   | c. (Last) <b>CROWE</b>   |  | 4. DATE OF DEATH (Month) (Day) (Year) <b>5-25-59</b>   |  |
| 5. SEX <b>Male</b>   |  | 6. COLOR OR RACE <b>White</b>   |   | 7. MARRIED, NEVER MARRIED, WIDOWED-DIVORCED (Specify) _____  |  | 8. DATE OF BIRTH <b>5-24-59</b>  |  |
| 9. AGE (In years last birthday) _____  |  | IF UNDER 1 YEAR Months _____ Days _____   |   | IF UNDER 24 HRS. Hours _____ Min. _____  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>   |  | 10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>  |   | 11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis Missouri</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 13a. FATHER'S NAME <b>Lawrence Crowe</b>   |  |   | 13b. MOTHER'S MAIDEN NAME <b>Joanne Mueller</b> |  |  | 14. NAME OF HUSBAND OR WIFE <b>Never Married</b>   |  |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>  |  | 16. SOCIAL SECURITY NO. <b>None</b>   |   | 17. INFORMANT'S SIGNATURE OR NAME <b>Mr. Lawrence Crowe</b>  |  | ADDRESS <b>5986 Theodosia</b>  |  |
| 18. CAUSE OF DEATH<br>Enter only one cause per line for (a), (b), and (c)<br><br>*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.  |  | MEDICAL CERTIFICATION<br>I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Helectasis</b><br><br>ANTECEDENT CAUSES<br>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.<br>DUE TO (b) <b>Prematurity</b><br>DUE TO (c) _____<br><br>II. OTHER SIGNIFICANT CONDITIONS<br>Conditions contributing to the death but not related to the disease or condition causing death. <b>762.5</b> |   |  |  | INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>  |  |
| 19a. DATE OF OPERATION _____   |  | 19b. MAJOR FINDINGS OF OPERATION _____  |   |  |  | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> 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) _____  |  |  |  |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____  |  | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21f. HOW DID INJURY OCCUR? _____   |  |  |  |
| 22. I hereby certify that I attended the deceased from <b>5-24</b> , 19 <b>59</b> , to <b>5-25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>5-24</b> , 19 <b>59</b> , and that death occurred at <b>9:26 A.M.</b> , from the causes and of the date stated above. |  |   |   |  |  |  |  |
| 23a. SIGNATURE <b>M. D.</b> (Degree or title)  |  |   |   | 23b. ADDRESS <b>8700 Riverview</b>   |  | 23c. DATE SIGNED <b>5-25-1959</b>  |  |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24b. DATE <b>5-26-1959</b>  |   | 24c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>   |  | 24d. LOCATION (City, town, or county) (State) <b>St. Louis Missouri</b>  |  |
| DATE REC'D BY LOCAL REG. <b>MAY 26 59</b>  |  | REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>   |   | 25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Jos. W. Clark F.H. 1125 Hodiamont</b>  |  |  |  |

WRITE PLAINLY—USING UNFAADING 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

*No Embalmed*  
*JR Matthews*

Signed .....

Licensed Embalmer No. ....

P. O. Address .....

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.