

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-016709

FILED VS MAY 2 1960

2 4251

STATE FILE NUMBER

Registrar's District No. Primary Registration District No. Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Saint Louis		Length of stay in 1b	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
		d. STREET ADDRESS (If outside, give location) 4301 Enright	
		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First MARY Middle T. Last CRAWFORD			4. DATE OF DEATH Month 4 Day 16 Year 1960			
---	--	--	--	--	--	--

5. SEX Female	6. COLOR OR RACE Negro	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 1/7/79	9. AGE (last birthday) 81	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.
------------------	---------------------------	---	----------------------------	------------------------------	--------------------------------	------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY --	11. BIRTHPLACE (City and state or country) Cadiz, Kentucky	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	---	---------------------------------------

13a. FATHER'S NAME Robert Thompson	13b. MOTHER'S MAIDEN NAME Ella Humphrey	14. NAME OF HUSBAND OR WIFE Tom Crawford
---------------------------------------	--	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	16. SOCIAL SECURITY NO. 488-01-0897A	17. INFORMANT Thomas Crawford	Address 4301 Enright
--	---	----------------------------------	-------------------------

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 4 months
IMMEDIATE CAUSE (a)	Coronary Heart Dis.	
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	DUE TO (b) H.C.V.D.	
	DUE TO (c)	4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown
---	---

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	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 WORK <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 Dec. 5, 1959 to April 16, 1960 and last saw him alive on 4-16-60 Death occurred at 4-16-60 11:40 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.
--

22a. SIGNATURE (Degree or title) Francis M. Whittier M.D.	22b. ADDRESS 916 A.W. Taylor.	22c. DATE SIGNED 4-18-60
--	----------------------------------	-----------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 4/21/60	23c. NAME OF CEMETERY OR CREMATORY Washington Park	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.
--	----------------------	---	--

24. FUNERAL DIRECTOR Charles J. Gates	ADDRESS 4107 Finney	25. DATE RECD. BY LOCAL REG. APR 19 1960	26. REGISTRAR'S SIGNATURE Kearl Smith, M.D. mjb
--	------------------------	---	---

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Guifon Swann

Licensed Embalmer No. 4580

P. O. Address 4107 Finney

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform 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.