

JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-017958

INDEXED

FILED VS APR 25 1960 319

Registration District No. 319 Primary Registration District No. 4469 Registrar's No. 25

STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>STE. GENEVIEVE</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>STE. GENEVIEVE</u>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>STE. GENEVIEVE</u>		Length of stay in 1b <u>1 YR</u>		c. CITY OR TOWN <u>STE. GENEVIEVE</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>930 RIDGEWAY</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>930 RIDGEWAY</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ABBOTT</u> Middle <u>AUGUST</u> Last <u>CRUMP</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>17</u> Year <u>1960</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>10/16/92 67</u>	9. AGE (last birthday) IF UNDER 1 YEAR: Months <u>67</u> Days <u>0</u> IF UNDER 24 HR: 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>LADDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LIME MFG.</u>		11. BIRTHPLACE (City and state or country) <u>STE. GENEVIEVE MO</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>AUGUST F. CRUMP</u>		13b. MOTHER'S MAIDEN NAME <u>LOUISE BEAUCHAMPT</u>		14. NAME OF HUSBAND OR WIFE <u>ELIZABETH WINTERS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WW I</u>		16. SOCIAL SECURITY NO. <u>492-07-2743</u>		17. INFORMANT Address <u>Mr. Glenn Hager, Ste. Genevieve 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>Cerebral hemorrhage</u> DUE TO (b) <u>arterial disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic myocarditis</u>					PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input 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 _____ a.m. _____ p.m. Month, Day, Year _____	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 <u>8-2-57</u> to <u>4-17-60</u> and last saw ^{her} him alive on <u>4-6-60</u> Death occurred at <u>10:30 a.m.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <u>Dr. Lansing M.D.</u> (Degree or title)			22b. ADDRESS <u>St. Genevieve Mo.</u>		22c. DATE SIGNED <u>4-18-60</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>4/19/60</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALLE SPRING</u>		23d. LOCATION (City, town, or county) <u>STE. GENEVIEVE MO</u>				
24. FUNERAL DIRECTOR <u>Rev. Paul H. Steneman Mo</u> ADDRESS _____			25. DATE RECD. BY LOCAL REG. <u>4/18/60</u>	26. REGISTRAR'S SIGNATURE <u>Kuill Bader</u>				

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

APR 26 1960

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 Adrian J. Ehler

Licensed Embalmer No. 4740

P. O. Address Ste. Deneve

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.