

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=60-020515

FILED VS MAY 18 1960

Registration District No. 310 Primary Registration District No. 3058 Registrar's No. 95

STATE FILE NUMBER

INDEXED

1. PLACE OF DEATH a. COUNTY <u>Saint Charles</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Charles</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Saint Charles</u>		Length of stay in 1b <u>25 yrs</u>	c. CITY OR TOWN <u>Saint Charles</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>Academy of Sacred Heart</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>Academy of Sacred Heart</u>	
3. NAME OF DECEASED (Type or print) First <u>Mother Helen</u> Middle <u>Crowe</u> Last <u>R.S.C.J.</u>			4. DATE OF DEATH Month <u>May</u> Day <u>6</u> Year <u>1960</u>		
5. SEX <u>Female</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>May 6, 1885</u>	9. AGE (last birthday) <u>75</u>	IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>teaching</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>religious</u>	11. BIRTHPLACE (City and state or country) <u>Waterloo, Illinois</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>Matthew J. Crowe</u>		13b. MOTHER'S MAIDEN NAME <u>Catherine Agnes Wall</u>		14. NAME OF HUSBAND OR WIFE <u>none</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Mother Fadberg, St. Charles, 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>Meningitis sec to Chronic Myelitis</u>					INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Fracture hip - 18 months</u>					<u>18 months</u>
DUE TO (c) <u>Parkinsonism 10 years -</u>					
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 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>1958</u> to <u>May 6, 1960</u> and last saw her ^{her} alive on <u>May 4, 1960</u> Death occurred at <u>5:45 A</u> m on the date stated above, and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) <u>Russell Hider MD</u>			22b. ADDRESS <u>St Charles, Mo</u>		22c. DATE SIGNED <u>May 6, 1960</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 9, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Convent Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Saint Charles, Mo.</u>	
24. FUNERAL DIRECTOR <u>H.C. Dallmeyer & Sons, St. Charles, Mo</u>		25. DATE RECD. BY LOCAL REG. <u>May 8-60</u>	26. REGISTRAR'S SIGNATURE <u>Margaret Wilson</u>		

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 Frank R. Amal
Licensed Embalmer No. 483
P. O. Address St. Charles

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.