

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8881

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY					
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Length of stay in 1b <u>10 Years</u>		c. CITY OR TOWN <u>St. Louis</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>6157 Pershing</u>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>6157 Pershing</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Della</u> Middle <u>Crawford</u> Last <u>CRAWFORD</u>				4. DATE OF DEATH Month <u>9-9-60</u> Day <u>9</u> Year <u>1960</u>					
5. SEX <u>Female</u>	6. COLOR OF 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>2-19-1866</u>	9. AGE (last birthday) <u>94</u>	IF UNDER 1 YEAR Months <u>6</u> Days <u>20</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>West Frankfort, Ill</u>		11. BIRTHPLACE (City and state or country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>		
13a. FATHER'S NAME <u>Thomas Jefferson Crawford</u>			13b. MOTHER'S MAIDEN NAME <u>Margaret Ann</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>Mrs. Joseph Maginnis, 6157 Pershing</u>			Address <u>St. Louis, 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>generalized arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>YEARS</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			DUE TO (b)		DUE TO (c) <u>450.0</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 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 <u></u> a.m. <u></u> p.m. <u></u> Month, Day, Year <u></u>									
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>Sept 9 1960</u> and last saw her/him alive on <u>Sept 9, 1960</u> Death occurred at <u>6:30 A.M.</u> <u>6:30</u> A.M. on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <u>Joseph P. Costello</u> (Degree or title) <u>Joseph P. Costello Jr. M.D.</u>				22b. ADDRESS <u>4952 Maryland</u>				22c. DATE SIGNED <u>9-9-60</u>	
23a. BURIAL OR CREMATION, RITUAL (Specify) <u>Burial</u>		23b. DATE <u>Sept. 10, 1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>			23d. LOCATION (City, town, or county) (State) <u>West Frankfort, Illinois</u>			
24. FUNERAL DIRECTOR <u>W. Kurwosh</u> ADDRESS <u>E. St. Louis, Ill.</u>			25. DATE RECD. BY LOCAL REG. <u>SEP 9 1960</u>		26. REGISTRAR'S SIGNATURE <u>Roal Smith, M.D.</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

Not Embalmed

Signed _____

[Handwritten Signature]

Licensed Embalmer No. 3162

P. O. Address E. St. Louis, Ill.

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.