

FILED VS. NOV 28 1960 318

DED

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 29 YRS.	c. CITY OR TOWN St. Louis
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Homer G. Phillips		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 2614 Caroline

3. NAME OF DECEASED (Type or print)	First Roy	Middle	Last Crawford	4. DATE OF DEATH	Month 11	Day 17	Year 60
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5. SEX Male	6. COLOR OR RACE Negro	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1888	9. AGE (last birthday) 72	IF UNDER 1 YEAR Months	IF UNDER 24 HR Days	Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter. Continental Baking Co.	10b. KIND OF BUSINESS OR INDUSTRY NONE	11. BIRTHPLACE (City and state or country) OAKLAND TENN	12. CITIZEN OF WHAT COUNTRY U.S.A
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13a. FATHER'S NAME SEBRON CRAWFORD	13b. MOTHER'S MAIDEN NAME UNKNOWN	14. NAME OF HUSBAND OR WIFE DECEASED
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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. 489-12-7566	17. INFORMANT ROBERT BIRDSONG	Address 5744 CHAMBERLAIN
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18. CAUSE OF DEATH (Enter only one cause per line for (d), (b), and (c). PART I. DEATH WAS CAUSED BY:		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Old Cerebral Vascular Accident		Undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Cerebral Thrombosis	Undet.
	DUE TO (c) 331X	

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	
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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.)
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20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year
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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
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21. I attended the deceased from **11-14-60**, to **11-17-60** and last saw him alive on **11-17-60**
Death occurred at **10:35** a.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE Audrey M. Shaw, M.D.	(Degree or title)	22b. ADDRESS 2601 N. Whittier St.	22c. DATE SIGNED 11-18-60
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23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE 11/23/60	23c. NAME OF CEMETERY OR CREMATORY FATHER DICKERSON CEMETERY	23d. LOCATION (City, town, or county) (State) KIRKWOOD MO
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24. FUNERAL DIRECTOR PRICE UNDERTAKING CO INC; 2829 WASHINGTON	ADDRESS	25. DATE RECD. BY LOCAL REG. NOV 19 1960	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.
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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 Edward A. Flynn

Licensed Embalmer No. 4444

P. O. Address 4205 Fins

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.