

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=61-011897

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 727

AMENDED

FILED MAR 30 1961

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>RICHMOND Hgts. CLAYTON</u>		Length of stay in 1b <u>2 MONTHS</u>	c. CITY OR TOWN <u>ST. LOUIS</u> Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>ST. MARYS HOSPITAL</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <u>6449 NOTTINGHAM</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <u>JULIA CRAWSHAW</u>			4. DATE OF DEATH Month Day Year <u>MARCH 14 1961</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>1/26/1890</u>	9. AGE (last birthday) <u>71</u>	IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	11. BIRTHPLACE (City and state or country) <u>ST. MARYS, MISSOURI</u>	12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13a. FATHER'S NAME <u>JULES DELACROTAZ</u>		13b. MOTHER'S MAIDEN NAME <u>JOSEPHINE MONTAVON</u>		14. NAME OF HUSBAND OR WIFE <u>JOHN CRAWSHAW</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			17. INFORMANT <u>JOHN CRAWSHAW</u> Address <u>SEE #2</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 Vascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>
DUE TO (b) <u>Cerebral Arteriosclerosis</u>		
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) <u>331x</u>		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Gangrene of Left Leg, hypothyroidism.</u>		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	
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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.)	
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 <u>1958</u> to <u>3-14-61</u> and last saw her alive on <u>3-14-61</u> Death occurred at <u>6:30 P.M.</u> on the date stated above, and to the best of my knowledge, from the causes stated.	COUNTY <u>ST. LOUIS</u>	STATE
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22a. SIGNATURE (Degree or title) <u>William T. Squard MD</u>	22b. ADDRESS <u>3915 WATSON RD.</u>	22c. DATE SIGNED <u>3-16-61</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>3/17/1961</u>	23c. NAME OF CEMETERY OR CREMATORY <u>VALHALLA CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>ST. LOUIS COUNTY, MISSOURI</u>
24. FUNERAL DIRECTOR <u>HOFFMEISTER COLONIAL MORTUARY</u> <u>6464 CHIPPEWA STREET, ST. LOUIS, MISSOURI</u>		25. DATE RECD. BY LOCAL REG. <u>3-16-61</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy</u>

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 DATE AMENDED
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed John S. Dennehy

Licensed Embalmer No. 4194

P. O. Address St. Louis, Mo.

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.