

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-004843
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 541 Registrar's No. 3

FILED JAN 19 1962

1. PLACE OF DEATH a. COUNTY <u>ST LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>CLAYTON</u>	Length of stay in 1b	c. CITY OR TOWN <u>Richmond Heights</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>DOA St. Louis County Hospital</u>		d. STREET ADDRESS (If outside, give location) <u>1139 Claytonia Terrace</u>	Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>LYDIA</u> Middle <u>KARBACH</u> Last <u>CROSSMAN</u>	4. DATE OF DEATH Month <u>January</u> Day <u>1</u> Year <u>1962</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</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>6/1/1884</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>0</u>	IF UNDER 24 HR Hours <u></u> Min. <u></u>
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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. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Christian Karbach</u>	13b. MOTHER'S MAIDEN NAME <u>Margaret Meyrer</u>	14. NAME OF HUSBAND OR WIFE <u>T. Clyde Crossman</u>
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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) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT Address <u>Mrs. Walter Karbach 6725 Leona St.</u>
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18. CAUSE OF DEATH (Enter only one cause by line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Over-dose of medication</u>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b)	
	DUE TO (c)	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e)		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 checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>Intentional ingestion of overdose of medication</u>
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20c. TIME OF INJURY Hour <u>8:00</u> Month, Day, Year <u>1/1/62</u>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>bedroom of home</u>	20f. CITY, TOWN, OR LOCATION <u>Richmond Heights St. Louis Missouri</u>
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21. I attended the deceased from _____ to _____ and last saw her him alive on _____ Death occurred at <u>DOA at 9:50</u> am on the date stated above, and to the best of my knowledge, from the causes stated.		
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22a. SIGNATURE (Degree or title) <u>Raymond T. Hand</u> Coroner <u>Clayton, Mo.</u>	22b. ADDRESS	22c. DATE SIGNED <u>1/2/62</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>Jan. 2, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lake Charles Cemetery St. Louis, Missouri</u>	23d. LOCATION (City, town, or county) (State)
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24. FUNERAL DIRECTOR ADDRESS <u>Ambruster Mortuary 6633 Clayton Road</u>	25. DATE RECD. BY LOCAL REG. <u>1-2-62</u>	26. REGISTRAR'S SIGNATURE <u>John B. Murphy M.D.</u>
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AMENDED
 DATE AMENDED
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 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 Ernest Hammer

Licensed Embalmer No. 4788

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.