

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-007931

318

Primary Registration District No. 1003

2143

STATE FILE NUMBER

AMENDED

Registration District No. **FILED FEB 28 1962**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Length of stay in 1b 67yrs.	c. CITY OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Lukes Hospital		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) 3522 Prairie Ave.		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle P. Last Crowe			4. DATE OF DEATH Month February Day 21 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9/21/94	9. AGE (last birthday) 67yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HR Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter (retired)		10b. KIND OF BUSINESS OR INDUSTRY N.Y. Central R.R.	11. BIRTHPLACE (City and state or country) St. Louis Mo.		12. CITIZEN OF WHAT COUNTRY U.S.	
13a. FATHER'S NAME Bernard Crowe		13b. MOTHER'S MAIDEN NAME		14. NAME OF HUSBAND OR WIFE Catherine Guessaz Crowe		
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.	17. INFORMANT Address Viola Feldkamp 4224a N. 21st. St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Post operative Pulmonary Embolus Acute					INTERVAL BETWEEN ONSET AND DEATH Acute	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) Hemolytic Anemia - Autoimmune	DUE TO (c)	6 Mon			
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 Feb 6 - 1962 to Feb 21 - 62 and last saw him alive on Feb 21 - 62 Death occurred at 9⁰⁰ p.m. on the date stated above, and to the best of my knowledge, from the causes stated.						
22a. SIGNATURE Wynne M. Suderman M.D. (Degree or title)			22b. ADDRESS 4943 Nat'l. Bridge		22c. DATE SIGNED 2/22/62	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Feb. 24, 1962	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) St. Louis Mo.		(State)
24. FUNERAL DIRECTOR Morrell 3710 N. Grand Blvd.			25. DATE RECD. BY LOCAL REG. FEB 23 1962	26. REGISTRAR'S SIGNATURE Koan Smith, M.D.		

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

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 me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Loron G. Percy

Licensed Embalmer No. 4094

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.