

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032371

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **8193** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

FILED AUG 31 1962	
1. PLACE OF DEATH a. COUNTY _____ b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN _____ Length of stay in lb _____ c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Little Sisters of the Poor <input type="checkbox"/>	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY _____ c. CITY OR TOWN St. Louis Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) 4508 Harris Ave Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First William Middle F. Last Crane	4. DATE OF DEATH Month 8 Day 20 Year 62
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 2-2-1874
9. AGE (last birthday) 88	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) Plumber	10b. KIND OF BUSINESS OR INDUSTRY Police Dept
11. BIRTHPLACE (City and state or country) St. Louis, Mo	12. CITIZEN OF WHAT COUNTRY U.S.
13a. FATHER'S NAME William Crane	13b. MOTHER'S MAIDEN NAME Lehan
14. NAME OF HUSBAND OR WIFE Genevieve Stack Crane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. _____
17. INFORMANT Mary Gilmartin Address 4508 Harris	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I. DEATH WAS CAUSED BY:	
IMMEDIATE CAUSE (a) Cardiac Decompenation	INTERVAL BETWEEN ONSET AND DEATH Five days
CONDITIONS, IF ANY, WHICH GAVE RISE TO ABOVE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.	DUE TO (b) A.S.H. Disease
	DUE TO (c) 4200
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) None	
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 _____ s.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 May 28 1962 to Aug 20 1962 and last saw him alive on Aug 20 1962 Death occurred at 6:30 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) Donald H. Flotte M.D.	22b. ADDRESS 2435 N. Grand Blvd
	22c. DATE SIGNED 8-21-62
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8-24-62
23c. NAME OF CEMETERY OR CREMATORY Cal vary	23d. LOCATION (City, town, or county) (State) St. Louis, Mo
24. FUNERAL DIRECTOR Welck Bros ADDRESS 2201 S. Grand	25. DATE RECD. BY LOCAL REG. 8-23-1962
	26. REGISTRAR'S SIGNATURE Loan Smith, M.D.

USE BLACK INK OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DATE AMENDED

DOCUMENT

BY AFFIDAVIT OF

VS 300 Rev. 4/59
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86

Dr. Bernard J. Zlatte
24357 Grand
Gr 5-4877

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 *Harry E. Monroe*

Licensed Embalmer No. *4495*

P. O. Address *St. Louis*

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.