

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

12252-62-048260  
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. \_\_\_\_\_

**FILED JAN 2 1962**

VS 300  
Rev. 4/59

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2 220

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12 75.0  
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO</b>		Length of stay in lb	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY		c. CITY OR TOWN <b>St. Louis</b>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) <b>2230 Madison St.</b>			Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>E.</b> Last <b>CRUSE</b>			4. DATE OF DEATH Month <b>DEC.</b> Day <b>19,</b> Year <b>1962</b>						
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>7/27/95</b>	9. AGE (last birthday) <b>67</b>	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) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		11. BIRTHPLACE (City and state or country) <b>Mason City Ill.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>			
13a. FATHER'S NAME <b>George M. Cruse</b>			13b. MOTHER'S MAIDEN NAME <b>Effie May Cates</b>		14. NAME OF HUSBAND OR WIFE <b>Ollie Cruse</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>			16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. O. Cruse 2230 Madison St.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory obstruction due to lung cancer</b> DUE TO (b) <b>Carcinoma of tongue</b> DUE TO (c) <b>141.9</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (e) <b>Radical Neck Dissection 24 hrs before death</b>						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			
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.		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 <b>12/13/62</b> to <b>12/19/62</b> and last saw her/him alive on <b>12/19/62</b> Death occurred at <b>7:30 A</b> m on the date stated above, and to the best of my knowledge, from the causes stated.									
22a. SIGNATURE <i>[Signature]</i>				22b. ADDRESS <b>1515 LAFAYETTE AVE</b>		22c. DATE SIGNED <b>12/19/62</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/22/62</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		23d. LOCATION (City, town, or county) <b>St. Louis MO.</b>			
24. FUNERAL DIRECTOR <b>Robert D. Kinealy 2228 St. Louis Ave.</b>				25. DATE RECD. BY LOCAL REG. <b>DEC 20 1962</b>		26. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

Dr. Cozart USE BLACK INK OR TYPEWRITER RIBBON

**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 Herbert J. Lane Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22 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.