

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-041329

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **10560**

FILED OCT 31 1963

1. PLACE OF DEATH a. COUNTY		b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MO.		Length of stay in 1b		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY		c. CITY OR TOWN ST. LOUIS		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. #1.				Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2724 SHERIDAN				Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) TORENZO BABY BOY CRAWFORD			First Middle Last			4. DATE OF DEATH 10 9 63			Month Day Year		
5. SEX MAL E		6. COLOR OR RACE NEGRO		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 10/8/63		9. AGE (last birthday)		IF UNDER 1 YEAR IF UNDER 24 HR Months Days 21 Yrs 25	
10a. USUAL OCCUPATION (Give kind of work done during most of life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (City and state or country) ST. LOUIS, MO		12. CITIZEN OF WHAT COUNTRY U.S.A			
13a. FATHER'S NAME JAMES CRAWFORD				13b. MOTHER'S MAIDEN NAME MARY LEE WILSON				14. NAME OF HUSBAND OR WIFE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If NO give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address ST. LOUIS CITY HOSP #1.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PREMATURITY										INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.				DUE TO (b) Intracranial Hemorrhage.							
				DUE TO (c) 760.5							
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 checked="" type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 10 8 63 to 10 9 63 and last saw her/him alive on 10 9 63 Death occurred at 8:05 PM m on the date stated above, and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE <i>Althabon M.D.</i>						22b. ADDRESS 1515 LAFAYETTE AVE.			22c. DATE SIGNED 10 9 63		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 10-31-63		23c. NAME OF CEMETERY OR CREMATORY Anatomical Board		23d. LOCATION (City, town, or county) St. Louis, Mo.		23e. (State)			
24. FUNERAL DIRECTOR ADDRESS MO. ANATOMICAL BOARD, 1402 S. GRAND				25. DATE RECD. BY LOCAL REG. OCT 24 1963		26. REGISTRAR'S SIGNATURE <i>Neal Smith, M.D.</i>					

DO NOT WRITE ON THIS STUB
 AMENDED
 VS 300 Rev. 4/59
 1
 2 **22**
 3
 4 **2**
 5 **0**
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 7 **0**
 8 **1**
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 11
 12 **75-0**
 13
 75
 AMENDMENTS ON THIS RECORD ARE AS FOLLOWS
 INSTEAD OF
 DOCUMENT
 MEDICAL CERTIFICATION
 SHOULD READ
 BY AFFIDAVIT OF
 ITEM NO.

Khatoon 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 _____

Licensed Embalmer No. _____

P. O. Address _____

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.