MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

9980

1. PLACE OF DEATH

County ..... Registration District No. 791 ~~1003~~

Township ..... Primary Registration District No. ..... File No. .....

City St. Louis (No. City Hospital St. ..... Ward) Registered No. 2556

1609 2

2. FULL NAME William (Crouch) Crouch

(a) Residence. No. 938 S Newstead St. 18 Ward. (If nonresident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1 1/2 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*write* the word)

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 25 - 1923

7. AGE: Years 3 | Months 7 | Days 18 | If LESS than 1 day, ... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) ..... (STATE OR COUNTRY) Michigan

PARENTS

10. NAME OF FATHER Wm Crouch
11. BIRTHPLACE OF FATHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri
12. MAIDEN NAME OF MOTHER Maine
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) ..... (STATE OR COUNTRY) Missouri

14. INFORMANT Hospital Information
(Address) City Hospital

15. FILED MAR 15 1927, 19..... Max C Starkoff REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) March 13 1927

17. I HEREBY CERTIFY, That I attended deceased from March 7, 1927, to March 13, 1927 that I last saw him alive on March 13, 1927, and that death occurred, on the date stated above, at 2:15 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Tuberculous Meningitis of the Meninges

3 1/2 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (SECONDARY) 32 a

..... (duration) ..... yrs. ..... mos. ..... ds.

18. WHERE WAS DISEASE CONTRACTED
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? .....
WHAT TEST CONFIRMED DIAGNOSIS? .....

(Signed) [signature], M. D

3/13, 1927 (Address) City Hospital

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL: Louisiana Mo
DATE OF BURIAL: 3-16-1927

20. UNDERTAKER: Geo L Pleitsch
ADDRESS: 5966 Easton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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