

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

Do not use this space.

1. PLACE OF DEATH

County.....

Registration District No. **791**

Township.....

Primary Registration District No. **1003**

City **St. Louis** (No. **City Hospital**)

File No. **25549**

Registered No. **7365**

St. _____

Ward _____

2. FULL NAME

(a) Residence. No. **1527 P 7** St. **23** Ward. _____
(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds.

How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX **Female** 4. COLOR OR RACE **White** 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 14 1928**

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
0 0 0

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) **St. Louis**
(STATE OR COUNTRY)

10. NAME OF FATHER **Alfred Crotchfield**

11. BIRTHPLACE OF FATHER (CITY OR TOWN) **Missouri**
(STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER **Ray Crotchfield**

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) **St. Louis**
(STATE OR COUNTRY)

14. INFORMANT **Edmund R. Sheridan**
(Address) **City Hospital**

15. FILED **7/16 1928** **May C. Stankley**
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) **July 14 1928**

17. I HEREBY CERTIFY That I attended deceased from **July 14 1928** to **July 14 1928** that I last saw him alive on **July 14 1928**, and that death occurred, on the date stated above, at **8:00 a.m.**

THE CAUSE OF DEATH* WAS AS FOLLOWS:

Insulin shock
about 6 months
159 (duration) yrs. mos. ds.

CONTRIBUTORY (SECONDARY) **161A**
duration yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED _____
IF NOT AT PLACE OF DEATH.....

19. DID AN OPERATION PRECEDE DEATH? _____ DATE OF _____
WAS THERE AN AUTOPSY? _____

WHAT TEST CONFIRMED DIAGNOSIS? _____
(Signed) **Edmund R. Sheridan, M.D.**
7/14 1928 (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.

PLACE OF BURIAL, CREMATION, OR REMOVAL **St. Louis** DATE OF BURIAL **7-16 1928**

20. UNDERTAKER **Wiley Bros 2201 So Grand**
ADDRESS

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

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.

Ortchfield