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

Do not use this space.

19667

File No. .....
Registered No. 5274

1. PLACE OF DEATH

County .....
Township .....
City St. Louis Mo. (No. 5600, Arsenal St. 24th Ward)

Registration District No. 781 St. Louis Mo
Primary Registration District No. .....

2. FULL NAME Clarence Crutcher

(a) Residence. No. 2033 Pine St., 21 Ward.
(Usual place of abode) (If nonresident give city or town and State)

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

PERSONAL AND STATISTICAL PARTICULARS

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

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

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Oct. 25-1925

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	3	6	14	

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9. BIRTHPLACE (CITY OR TOWN) Tennessee
(STATE OR COUNTY)

PARENTS

10. NAME OF FATHER Clarence Crutcher
11. BIRTHPLACE OF FATHER (CITY OR TOWN) Tennessee
(STATE OR COUNTY)
12. MAIDEN NAME OF MOTHER Lulu Johnson
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) .....
(STATE OR COUNTY) Tennessee

14. INFORMANT Miss May Hedrick
(Address) Isolation Hospital

15. FILED MAY 11 1929 May C. Hartley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) May 9 1929

17. I HEREBY CERTIFY, That I attended deceased from May 9th, 19..., to May 9, 1929 that I last saw h. alive on May 9th, 1929, and that death occurred, on the date stated above, at 10:55 P.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Epidemic Meningitis

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (SECONDARY) .....
(duration) ....yrs. ....mos. ....ds.

18. WHERE WAS DISEASE CONTRACTED Dont Know
IF NOT AT PLACE OF DEATH? .....
DID AN OPERATION PRECEDE DEATH? ..... DATE OF .....
WAS THERE AN AUTOPSY? no
WHAT TEST CONFIRMED DIAGNOSIS? Spinal puncture amount 4 drams of fluid
(Signed) J. M. Perry, M. D
, 19 (Address) 5600 Arsenal St.

*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 E. St. Louis Ill — DATE OF BURIAL May 11 1929

20. UNDERTAKER J. Kularshall — ADDRESS E St. Ill

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.

THIS IS A PERMANENT RECORD