

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

Do not use this space.

6719

1. PLACE OF DEATH

County..... Registration District No. **791**
 Township..... **St. Louis** Primary Registration District No. **1003**
 City..... **St. Louis** (No. **5600**, **Arsenal**)

File No.....
 Registered No. **1544**
 St. **24th** Ward

2. FULL NAME *Jay Crimmins*

(a) Residence No. **107 Victor** 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 **21** yrs. **1** mos. **8** 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 *Married*
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF *John Crimmins*

6. DATE OF BIRTH (MONTH, DAY AND YEAR) *Jan. 3, 1909*
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
21 1 5

8. OCCUPATION OF DECEASED
 (a) Trade, profession, or particular kind of work *Housewife*
 (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) *Mo.*

10. NAME OF FATHER *Ges. Weber*
11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*
12. MAIDEN NAME OF MOTHER *Mattie Moon*
13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY) *Mo.*

14. INFORMANT *Lorraine Krouer*
 (Address) *ISOLATION HOSPITAL*

15. FILED 19 *30* *Jan 11* REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) *2-11* 19 *30*

17. I HEREBY CERTIFY, That I attended deceased from *2-9* 19 *30*, to *2-11* 19 *30*, that I last saw *h* alive on *2-11* 19 *30* and that death occurred, on the date stated above, at *6:15 P. m.*

THE CAUSE OF DEATH* WAS AS FOLLOWS:
Meningitis meningococci
18

CONTRIBUTORY (SECONDARY) *24* (duration) yrs. mos. *4* ds.

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

8 DID AN OPERATION PRECEDE DEATH?..... DATE OF.....

WAS THERE AN AUTOPSY?.....

WHAT TEST CONFIRMED DIAGNOSIS.....
 (Signed) *R. K. K. K.* M. D.
2-12 19 *30* (Address) **ISOLATION 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 *Sullivan Mo* DATE OF BURIAL *2-13* 19 *30*

20. UNDERTAKER *Schaffer Und.* ADDRESS *Sullivan Mo*

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.

7-10-1963

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