

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.

15 1939

DEC'D JUN 8 1939

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

19694  
 Do not use this space.

1. PLACE OF DEATH  
 (a) County St. Louis Registration District No. 784  
 (b) Township Clayton Primary Registration District No. 101 Registered No. 881  
 (c) City Clayton (d) Street No. St. Louis County Hospital St.  
 (If death occurred in Hospital or Institution, write its name instead of street and number)  
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Archie Crosson  
 (a) Residence, No. 2617 Sutton, Maplewood, Mo. St.  (If nonresident, give city or town and State)  
 (Usual place of abode, if no street address, write county or city)

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX male 4. COLOR OR RACE white 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Nora Crosson  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Dec. 25, 1875  
 7. AGE YEARS 63 MONTHS 4 DAYS 18 If LESS than 1 day, ..... hrs. or ..... min.  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. janitor  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada  
 FATHER 13. NAME David Crosson  
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada  
 MOTHER 15. MAIDEN NAME Catherine McKay  
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Canada  
 17. INFORMANT wife, Nora Crosson  
 (ADDRESS) 2617 Sutton, Maplewood, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Oak Hill Cem. DATE May 15, 1939  
 19. FUNERAL DIRECTOR (NAME) Jay B. Smith  
 (ADDRESS) 7456 Manchester  
 20. FILED MAY 15 1939 G. R. Meyer Local Registrar

**MEDICAL CERTIFICATE OF DEATH**

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 5-13-39, 19  
 22. I HEREBY CERTIFY, That I attended deceased from 3-17-39, 19, to 4-13-39, 19.  
 I last saw him alive on 4-13-39, 19. Death is said to have occurred on the date stated above, at 6:15 P. M.  
 The principal cause of death and related causes of importance were as follows:  
Stricture of the urethra  
 Date of onset 3/17/39  
 Other contributory causes of importance: 136  
 Name of operation..... Date of.....  
 What test confirmed diagnosis?..... Was there an autopsy?.....  
 23. If death was due to external causes (violence), fill in also the following:  
 Accident, suicide, or homicide?..... Date of injury....., 19.....  
 Where did injury occur?..... (Specify city or town, county, and State)  
 Specify whether injury occurred in industry, in home, or in public place.  
 Manner of injury.....  
 Nature of injury.....  
 24. Was disease or injury in any way related to occupation of deceased?.....  
 If so, specify L. M. Cronberg, M. D.  
 (Signed) St. Louis (Deaths Dept) (Address)

**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.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

*H. Burgess*

Licensed Embalmer No. 4029

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 this body is not embalmed, above space should be left blank.**