

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE 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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37740
Registrar's No. 9579

Registration District No. 791

Primary Registration District No. _____

1. PLACE OF DEATH: 1003
(a) County _____
(b) City or town St. Louis
(c) Name of hospital or institution: Homer G. Phillips Hosp
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 14 days
(Specify whether
In this community Unknown
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County _____
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. 1917 Division Street
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

3. (a) PRINT FULL NAME Jennie Crawford
8. (b) If veteran, name war No 8. (c) Social Security No. None

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month 11 day 6
year 1939 hour 1:55 minute A. M.

4. Sex Female 5. Color or race Col 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Harrison Crawford 6. (c) Age of husband or wife if alive Dead years
7. Birth date of deceased Aug Unknown
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from 11-24-, 1939 to 11-6-, 1939
that I last saw her alive on 11-6, 1939
and that death occurred on the date and hour stated above.

8. AGE: Years _____ Months _____ Days _____ If less than one day
About 61 hr. _____ min.

Immediate cause of death Bronchopneumonia 2 days
(Terminal)
Due to Arteriosclerosis About 1 year

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
10. Usual occupation Housework
11. Industry or business _____
12. Name Abe Liggins
13. Birthplace Unknown (City, town, or county) _____ (State or foreign country)
14. Maiden name India Kelly
15. Birthplace Unknown (City, town, or county) _____ (State or foreign country)

Other conditions (Include pregnancy within 3 months of death) _____
Major findings: _____
Of operations _____
Of autopsy _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

16. (a) Informant's own signature Mrs. Sarah Bell Allen
(b) Address 1110 East St. Muskegon, Mich.
17. (a) Burial (b) Date thereof Nov 10 39
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Washington Park
18. (a) Signature of funeral director J. W. Hughes
(b) Address 2620 E. Boston
19. (a) NOV 9 1939 (b) J. F. Bredel
(Date received local Registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
23. Signature H. J. Lyman (M. D. or other)
Address 2601 N. Whittier Date signed 11-6-1939

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 *Leda Hughes*
Licensed Embalmer No. *2938*
P. O. Address *St Louis mo*

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.