

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 9368
Registrar's No. 2851

Registration District No. 791

Primary Registration District No. 1003

1. PLACE OF DEATH:

(a) County _____
(b) City or town St. Louis, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: City Hospital, #1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 8 hrs. 7 mins.
(Specify whether
In this community 8 hrs. 7 mins.
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County X
(c) City or town St. Louis 26
(If outside city or town limits, write "RURAL")
(d) Street No. 2804 North Broadway
(If rural, give location)
(e) If foreign born, how long in U. S. A. ? _____ years.

3. (a) PRINT FULL NAME Baby Crader #1

3. (b) If veteran, name war _____ 3. (c) Social Security No. Unknown

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Single

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased: March 2, 1940
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day 8 hr. 7 min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Nil.

11. Industry or business Nil.

MOTHER { 12. Name Charles Crader

13. Birthplace _____ Ark. 1
(City, town, or county) (State or foreign country)

14. Maiden name Matilda Duersmeyer

15. Birthplace _____ Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Ann Morrison

(b) Address City Hospital, #1

17. (a) Cremation (b) Date thereof 2/29/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place of burial or cremation City Hospital

18. (a) Signature of funeral director [Signature]

(b) Address City Hospital

19. (a) MAR 27 (b) [Signature]
(Date received local register) (Date of registration)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 2,
year 1940 hour 4:20 minute _____ P. _____ M.

21. I hereby certify that I attended the deceased from March 2, 1940 to March 2, 1940
that I last saw her alive on March 2, 1940
and that death occurred on the date and hour stated above.

Immediate cause of death _____
Pneumonia

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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 [Signature] (M. D. or other) _____

Address 1515 Lafayette, Date signed 3/4/40

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.....

Licensed Embalmer No.....

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.