

WHITE PLYMOUTH USE OVERPRINTING BLACK INK WHEN A PLUMBER 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.

Registration District No. 425

Primary Registration District No. 0580

**1. PLACE OF DEATH:**  
 (a) County JEFFERSON  
 (b) City or town RURAL - MERAMEC  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: ST. JOSEPH'S HILL INFIRMARY  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 33 DAYS  
 (Specify whether  
 In this community  
 years, months or days) 1

3. (a) PRINT FULL NAME BURLEIGH R. CROMLEY  
 3. (b) If veteran, name war NONE  
 3. (c) Social Security No. NONE

4. Sex MALE 5. Color or race WHITE  
 6. (a) Single, widowed, married, divorced MARRIED  
 6. (b) Name of husband or wife MARY TAYLOR  
 6. (c) Age of husband or wife If alive 67 years  
 7. Birth date of deceased 11 28 1867  
 (Month) (Day) (Year)

8. AGE: Years 72 Months 4 Days 26  
 If less than one day hr. min.

9. Birthplace CIRCLEVILLE OHIO  
 (City, town, or county) (State or foreign country)

10. Usual occupation R. R. CONDUCTOR, RETIRED

11. Industry or business MO. PAC. R. R.

**MOTHER FATHER**  
 12. Name HENRY CROMLEY  
 13. Birthplace CIRCLEVILLE OHIO  
 (City, town, or county) (State or foreign country)  
 14. Maiden name ANNA  
 15. Birthplace CIRCLEVILLE OHIO  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Arthur Bonaventura  
 (b) Address St. Joseph's Hill Infirmary - Cuba  
 17. (a) Cremation (b) Date thereof 4 24 1940  
 (Specify cremation, or removal) (Month) (Day) (Year)  
 (c) Place: Valhalla Crem.

18. (a) Signature of funeral director J. M. Mullen  
 (b) Address 5165 Delmas  
 19. (a) 24 April 40 (b) James A. Downes  
 (Date received local registrar) (Registrar's signature)

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State MISSOURI (b) County St. Louis  
 (c) City or town UNIVERSITY CITY  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 7518 CORNWALL DRIVE,  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A? \_\_\_\_\_ years.

**MEDICAL CERTIFICATION**  
 20. DATE OF DEATH: Month April day 24  
 year 1940 hour 5 minute 55 A. M.  
 21. I hereby certify that I attended the deceased from March 23, 1940, to Apr. 20, 1940  
 that I last saw him alive on Apr. 20, 1940  
 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of the Throat  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 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

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?  
 \_\_\_\_\_  
 \_\_\_\_\_ (Specify type of place) \_\_\_\_\_  
 While at work? \_\_\_\_\_ (e) Means of injury \_\_\_\_\_  
 23. Signature Leslie S. Sargent (M. D. or other)  
 Address Cuba, Mo. Date signed 4-26-40

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**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.**