

1. PLACE OF DEATH:

(a) County _____
 (b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
5844 a Roosevelt Place 2
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution _____
(Specify whether
 In this community _____
years, months or days)

3. (a) PRINT FULL NAME Agnes E. Crowley 640

3. (b) If veteran, name war _____ 3. (c) Social Security No. None

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

6. (b) Name of husband or wife John J Crowley 6: (c) Age of husband or wife 64 years

7. Birth date of deceased April 17th 1878
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	62	0	20	hr. <u>5</u> min. <u>0</u>

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

10. Usual occupation Housewife

11. Industry or business _____

12. Name John Fleming

13. Birthplace Ireland
(City, town, or county) (State or foreign country)

14. Maiden name Eileen Shannon
(City, town, or county) (State or foreign country)

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

16. (a) Informant John J. Crowley

(b) Address 5844 a Roosevelt Place

17. (a) Burial (b) Date thereof 5/10/40
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Calvary Cemetery

18. (a) Signature of funeral director Stroot - Carroll

(b) Address 4600 Natural Bridge Ave

19. (a) 5844 (b) J.P. Bruck
(Date recorded local registrar) (Signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County _____
 (c) City or town St. Louis 6
(If outside city or town limit, write "RURAL")
 (d) Street No. 5844 a Roosevelt Place
(If rural, give location)
 (e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 7th
 year 1940 hour 2 minute 55a M.

21. I hereby certify that I attended the deceased from Jan 1940 to May 6 1940
 that I last saw her alive on May 6 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Bronchitis (not tubercular)

Due to _____

Due to _____

Other conditions None
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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 W.N. White (M. D. or other) md

Address 2803 N Kingshighway Date signed 5-7-40

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 Sheldon Collier

Licensed Embalmer No. 3382

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.