

NOV 16 1940 791

Primary Registration District No. **1003**

Registrar's No. **8194**

1. PLACE OF DEATH:

(a) County _____
(b) City or town **St. Louis Mo.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Stones Nursing Home 4373 W. Pine**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **30 days**
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME **William Henry Crawford**

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 **wid.**
6. (b) Name of husband or wife **Mary Josephine Tobin** 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased **Oct 7, 1865**
(Month) (Day) (Year)

8. AGE: Years **74** Months **11** Days **24** If less than one day hr. _____ min.

9. Birthplace **Boston Mass**
(City, town, or county) (State or foreign country)

10. Usual occupation **Shoe Mfg.**

11. Industry or business _____

12. Name **Unknown**
13. Birthplace **Unknown**
(City, town, or county) (State or foreign country)
14. Maiden name **Unknown**
15. Birthplace **Unknown**
(City, town, or county) (State or foreign country)

16. (a) Informant **Dr. Louis Crawford**
(b) Address **Indianapolis Ind.**

17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **10/2/40**
(Month) (Day) (Year)

(c) Place: burial or cremation **St. Matthews**

18. (a) Signature of funeral director **C. Mayer**
(b) Address **4356 Lindell Blvd**

19. (a) **OCT 2 1940** (b) **J. T. Baudach**
(Date received for registration) (Signature)

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. **4373 West Pine Blvd**
(If rural, give location)
(e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct.** day **1**
year **1940** hour **2** minute **15 A.M.**

21. I hereby certify that I attended the deceased from **July 30**
_____, 1940, to **Oct 27**, 1940;
that I last saw him alive on **Sept. 27**, 1940;
and that death occurred on the date and hour stated above.

Immediate cause of death **Degenerative heart disease** Duration **4 yrs**

Due to _____

Due to _____

Other conditions **Cachexia**
(Include pregnancy within 3 months of death) **6 mo**

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? _____

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **E. M. Charles** (M. D. or other) **Dr.**
Address **632 Metropolitan Bldg** Date signed **10-1-40**

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.....

J. S. Sullivan

Licensed Embalmer No. 1122

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, fact should be so stated above.