

FILED MAR 13 1944 318

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Registration District No. Primary Registration District No. Registrar's No. 2225

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

1. PLACE OF DEATH:

(a) County St. Louis Mo.
(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 BARNES HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 9 days (Specify whether years, months or days)

3. (a) PRINT FULL NAME Dennis Charles Crotchett

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 Single

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

7. Birth date of deceased _____ (Month) (Day) (Year)

8. AGE: abt-17 Years Months Days If less than one day hr. min.

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

10. Usual occupation Student

11. Industry or business _____

12. Name Wallace Crotchett

13. Birthplace Creighton Mo. Missouri (City, town, or county) (State or foreign country)

14. Maiden name Nellie Burge

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

16. (a) Informant Wallace Crotchett

(b) Address Creighton, Mo.

17. (a) Burial (b) Date thereof 3-7-44 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Creighton, Mo.

18. (a) Signature of funeral director Albert H. Hoppe

(b) Address 4700 Washington Blvd.

19. (a) MAR 6 1944 (Date received local registrar) J. F. [Signature] (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Cass
(c) City or town Creighton (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 3rd year 1944 hour 3 minute 45 P. M.

21. I hereby certify that I attended the deceased from February 23, 1944, to March 3rd, 1944 that I last saw him alive on March 3, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death _____ Duration _____

Bronchopneumonia

Due to Acute lymphatic leukemia

Due to _____

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

Major findings: Of operations _____

Of autopsy diffuse lymphadenopathy Bronchopneumonia - bilateral

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

Address BARNES HOSPITAL Date signed 3/3/44

PHYSICIAN

Underline the cause to which death should be charged statistically.

844

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 *Albert G. Hopper*.....
.....
Licensed Embalmer No..... 2971
.....
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.