

FILED JAN 20 1945
318
Registration District No.

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County St. Louis, Missouri

(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:
Homer G. Phillips Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 23 days (Specify whether)

In this community 17 years
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Louis

(c) City or town St. Louis
(If outside city or town limits, write "RURAL")

(d) Street No. 3006 Market St.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Katie Crittendon

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 5,
year 1945 hour 5 minute 20 P. M.

21. I hereby certify that I attended the deceased from December 13, 1944 to January 5, 1945
that I last saw her alive on January 5, 1945
and that death occurred on the date and hour stated above.

4. Sex FEMALE 5. Color or race Col

6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife JOHN H. CRITTENDON

6. (c) Age of husband or wife if alive 59 years

7. Birth date of deceased JULY 2 1902
(Month) (Day) (Year)

Immediate cause of death Myoma of uterus

Duration Unk.

Due to _____

Due to _____

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

8. AGE: Years Months Days If less than one day

NOT 42 6 3 hr. min.

9. Birthplace STARKVILLE MISS
(City, town, or county) (State or foreign country)

10. Usual occupation DOMESTIC

11. Industry or business _____

MOTHER FATHER { 12. Name UNK

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

14. Maiden name PAITE THOMAS

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

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

Major findings:
Of operations _____

Of autopsy _____

16. (a) Informant PAITE THOMAS

(b) Address 3006 MARKET ST

17. (a) REMOVAL (Burial, cremation, or removal)

(b) Date thereof JAN 12 1945
(Month) (Day) (Year)

(c) Place: burial or cremation STARKVILLE MISS

18. (a) Signature of funeral director A. L. BOGAL

(b) Address 2726 LUCAS AVE.

19. (a) JAN 9 1945 (Date received local registrar)

(b) J. F. BRIDICK (Registrar's signature)

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 D. E. Courtney (M. D.)

Address 2601 W. HITTIER Date signed 1/8/45

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 Arthur L. Hilliard
Licensed Embalmer No. 4221
P. O. Address 1154 Bayard

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.