

7. S. No. 2
FORM-5-43
Rev. 5-17-39
I X3667

FILED JAN 25 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

(b) City or town St. Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
St. John's Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution. 0
(Specify whether)

In this community 0
years, months or days

3. (a) PRINT FULL NAME Gary R. Croquart

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

4. Sex Male 5. Color or race White

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

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

7. Birth date of deceased January 10 1945
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days 3 If less than one day _____ hr. _____ min.

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

10. Usual occupation Infant

11. Industry or business _____

12. Name Oliver Croquart

13. Birthplace St. Charles Missouri
(City, town, or county) (State or foreign country)

14. Maiden name Mary Larue

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

16. (a) Informant Oliver Croquart

(b) Address 5030 Cabanne Ave.

17. (a) Burial (b) Date thereof 1-18-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winfield, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) JAN 19 1945 (b) J. J. Brudeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County 000

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

(d) Street No. 5030 Cabanne Ave.
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 13
year 1945 hour 6:00 minute P. M.

21. I hereby certify that I attended the deceased from but 1945 to Jan 13 1945
that I last saw her alive on Jan 13 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Spinal Reflex fall

Due to _____

Due to Born with spinal Reflex fall

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

PHYSICIAN

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) no

(b) Date of occurrence no

(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? no

While at work? no (Specify type of place) (e) Means of injury _____

23. Signature W. J. Brudeck (M. D. or other) 157

Address 1550 Myrtle Date signed 1/13/45

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 *Albert W. Koppie*

Licensed Embalmer No. *1861*

P. Q. 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.