S. No. 2
0M—2-43
v. 5-17-39
I X35897

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 23 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 1118

Registration District No. 818 Primary Registration District No. 1003 Registrar's No. 3267

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: City Sanitarium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 26yrs 8mos 29ds (Specify whether years, months or days)
In this community 34 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County 13
(c) City or town St. Louis
(If outside city or town limits, write "RURAL")
(d) Street No. ~~3214 Morgan St~~ City Sanitarium (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME WILLIAM C. CRAWFORD
3. (b) If veteran, name war ---
3. (c) Social Security No.

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 October 25 (Month) (Day) 1892 (Year)

8. AGE: Years 52 Months 5 Days 16 If less than one day hr. min.

9. Birthplace Tennessee (City, town, or county) (State or foreign country)
10. Usual occupation Shoe Worker
11. Industry or business -
FATHER
12. Name William Crawford
13. Birthplace not known (City, town, or county) Tennessee (State or foreign country)
MOTHER
14. Maiden name Minnie ?
15. Birthplace not known (City, town, or county) Tennessee (State or foreign country)
16. (a) Informant City Sanitarium
(b) Address 5400 Arsenal St
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/13/45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park
18. (a) Signature of undertaker Harrigan & Sheahan Und Co
(b) Address 4415 Washington Blvd.
19. (a) APR 12 1945 (Date received local registrar) (b) J. H. Brueck (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11 year 1945 hour 5:33 minute P. M.
21. I hereby certify that I attended the deceased from Jan. 1, 1944 to April 11 1945 that I last saw him alive on April 11 1945 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Myocarditis	1945x
Chronic Nephritis	1944x
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy No	

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

23. Signature Palmer Romaine Rowland (M. D. or other)
Address 5400 Arsenal Date signed 4/12/45

(Licensed Embalmer's Statement on Reverse Side)

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 G. W. Wilkinson

Licensed Embalmer No. 35-78

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.