V. S. No. 2
00M—5-43
ev. 5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 4 1945

Registration District No. 317

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18046

Primary Registration District No. 6076

Registrar's No. 1016

1. PLACE OF DEATH:

(a) County St. Louis

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

(c) Name of hospital or institution:
Bellefontaine Nursing Home 4
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether
In this community ..... years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County CCO

(c) City or town St. Louis 11
(If outside city or town limits, write "RURAL")

(d) Street No. 4557 Pope Ave. 9
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Elizabeth M. Crothers

3. (b) If veteran, name war ..... 3. (c) Social Security No. .....

4. Sex Female 1 | 5. Color or race White | 6. (a) Single, widowed, married, divorced Widowed 2

6. (b) Name of husband or wife Thomas Crothers | 6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased July (Month) 29 (Day) 1874 (Year)

8. AGE: Years 70 | Months 8 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) Scotland 1 (State or foreign country)

10. Usual occupation Housewife 1

11. Industry or business .....

FATHER
12. Name Thomas Boyne
13. Birthplace ..... (City, town, or county) Scotland 4 (State or foreign country)

MOTHER
14. Maiden name Marion Williamson
15. Birthplace ..... (City, town, or county) Scotland 4 (State or foreign country)

16. (a) Informant Mrs. William Fisher
(b) Address 4557 Pope Ave.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation Memorial Park

18. (a) Signature of funeral director Drehmann-Harral
(b) Address 1905 Union Blvd.

19. (a) MAY 2 1945 (Date received local registrar) (b) E. E. McCourow MD (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr. day 24
year 1945 hour 6 minute 50 P.M.

21. I hereby certify that I attended the deceased from April 24, 1945 to April 24, 1945
that I last saw her alive on April 24, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death
Arteriosclerosis
Myocardial cerebrals

Due to
83a

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

Duration

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 [illegible] (M. D. or other)
Address 1918 Rutgrand Date signed

707

(Licensed Embalmer's Statement on Reverse Side)

1918 E. Grand Blvd.
9 to 10 & 1 to 3

JUN 26 1945

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 Warren A. Carver

Licensed Embalmer No. 3534

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.