

S. No. 2  
OM-2-43  
v. 5-17-39  
X35697

22071

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

FILED JUL 20 1945  
Registration District No. 318

Primary Registration District No. 1003

Registrar's No. 6098

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:  
Missouri Baptist Hospital  
(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 Missouri (b) County St. Francois

(c) City or town Cantwell  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Annabelle Holmes

3. (b) If veteran, name war Nil

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 10  
year 1945 hour 1:45 minute \_\_\_\_\_ P. \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from 7-3-1945  
to 7-10-1945  
that I last saw her alive on 7-10-1945  
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife Fred Holmes

6. (c) Age of husband or wife if alive 69 years

7. Birth date of deceased September 10 1884  
(Month) (Day) (Year)

Immediate cause of death Carcinoma of Ovary Duration Indefinite

8. AGE:	Years	Months	Days	If less than one day
	<u>60</u>	<u>10</u>	<u>0</u>	hr. _____ min. _____

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: Ovarian Carcinoma

Of autopsy none made

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name William Crunckleton

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

14. Maiden name Caroline A. Ashburn

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

16. (a) Informant Julia Cole

(b) Address 3412 Oxford, Maplewood, Mo.

17. (a) Burial (b) Date thereof 7-12-45  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Farmington, Missouri

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

(b) Address 4700 Washington Blvd.

19. (a) JUL 13 1945 (b) J. T. Braden  
(Date received by Registrar) (Registrar's signature)

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? \_\_\_\_\_

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

23. Signature John D. Hayward (M. D. or other) \_\_\_\_\_

Address Metropolitan Bldg. Date signed 7/11/45

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

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**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.....

*W. Wilkin*

Licensed Embalmer No..... *3575*

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.**