

FILED MAR 30 1946

318

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No.

Primary Registration District No.

1003

Registrar's No.

2702

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:  
Homer G Phillips Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 9 days  
In this community abt 6 yrs (Specify whether years, months or days)

3. (a) PRINT FULL NAME William Crowley

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

4. Sex Male 5. Color or race col 6. (a) Single, widowed, married, divorced wid  
6. (b) Name of husband or wife 6. (c) Age of husband or wife if alive years  
7. Birth date of deceased (Month) (Day) (Year) 1872

8. AGE: Years abt 74 Months Days If less than one day hr. min.

9. Birthplace Columbia Tenn (City, town, or county) (State or foreign country)  
10. Usual occupation unemployed

11. Industry or business  
12. Name Walter Crowley  
13. Birthplace Tenn (City, town, or county) (State or foreign country)  
14. Maiden name Lillie Goodlow  
15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant William Crowley  
(b) Address 1403 Horton St  
17. (a) Burial (b) Date thereof 3-22-46  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place: burial or cremation Washington Park

18. (a) Signature of funeral director W. M. Green  
(b) Address 561 Beale Ave  
19. (a) MAR 21 1946 F. J. Brudek  
(Date received local authority) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County osc  
(c) City or town St. Louis  
(If outside city or town limits, write "RURAL")  
(d) Street No. 4207 E Garfield  
(If rural, give location)  
(e) Citizen of foreign country? (Yes or No) No  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar. day 18  
year 1946 hour 10 minute 15 A.M.

21. I hereby certify that I attended the deceased from 9-9 to 3-18  
that I last saw him alive on 3-18  
and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Glomerulonephritis with Uremia; Senility

Duration

Unk

Due to 1/21  
Due to

Other conditions: Hypertensive Heart Disease  
(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?

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

23. Signature F. B. Turcotte (M. D. or other)  
Address 2601 N Whittier Date signed 3/20/46

MOTHER FATHER

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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.....

*A. P. Green*

Licensed Embalmer No. *1173*

P. O. Address. *3517 So. 4th St.*

**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.**

Registration District No. 318

Primary Registration District No. 1003

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:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. (Specify whether  
In this community \_\_\_\_\_ (Specify whether  
years, months or days)

3. (a) PRINT FULL NAME William Crawley

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

4. Sex m 5. Color or race B 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased. (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year) \_\_\_\_\_

8. AGE: Years 54 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation \_\_\_\_\_

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

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) J. F. Bredek (Registrar's signature)  
(Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (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 \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH, Month Mar (Day) \_\_\_\_\_ year 1946 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_; that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death \_\_\_\_\_

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

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

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 \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

APR 6 1946

11026