No. 2
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JUN 13 1947

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 18719

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5117

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:
Enroute to Homer G. Phillips Hosp.
(If not in hospital or institution, write street number or location)

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

In this community Life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County

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

(d) Street No. 789 Aubert Avenue
(If rural, give location)

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

If yes, name country

3. (a) PRINT FULL NAME Catherine Cooper Crenshaw

3. (b) If veteran, name war

3. (c) Social Security No. 487-32-7336

4. Sex Female

5. Color or race Negro

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

6. (b) Name of husband or wife James Crenshaw

6. (c) Age of husband or wife if alive 33 years

7. Birth date of deceased September 13 1913
(Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
33	8	15	hr. min.

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

10. Usual occupation Nurses' Aid

11. Industry or business

MOTHER FATHER

12. Name Malachi Cooper

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

14. Maiden name Delia Cowan

15. Birthplace Danville, Kentucky
(City, town, or county) (State or foreign country)

16. (a) Informant Delia Cooper

(b) Address 789 Aubert Avenue

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2, 1947 (Month) (Day) (Year)

(c) Place: burial or cremation Washington Park Cem.

18. (a) Signature of funeral director Chas. J. Gates

(b) Address 4107 Finney Avenue

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 28th year 1947 hour 6 minute 30 A. M.

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death

Due to

Due to

Duration

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

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 (M. D. or other)

Address 1300 Clark Avenue Date signed 8/29/47

(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

John K. Cunningham, Registered Apprentice No. 452,

working under my personal supervision.

Signed

Licensed Embalmer No. 1825

P. O. Address 4107 Finney Avenue

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.