

No. 2  
12-45  
5-17-39  
X47070

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED MAR 19 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

9858  
State File No. \_\_\_\_\_  
Registrar's No. 52

Registration District No. 310 Primary Registration District No. 3058

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

1. PLACE OF DEATH:  
(a) County St. Charles  
(b) City or town St. Charles  
(c) Name of hospital or institution St. Joseph Hospital  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community \_\_\_\_\_  
years, months or days

2. USUAL RESIDENCE OF DECEASED:  
(a) State Missouri (b) County St. Louis  
(c) City or town St. Louis  
(d) Street No. 2429 Oakland Ave.  
(e) Citizen of foreign country? \_\_\_\_\_  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Donna Sue Crossman  
(b) If veteran, name war \_\_\_\_\_ (c) Social Security No. \_\_\_\_\_  
4. Sex Female 5. Color or race white  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased March 10 1948  
(Month) (Day) (Year)

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month MARCH day 10 year 1948 hour 1 minute 30 P.M.  
21. I hereby certify that I attended the deceased from 3/9/1948 to 3/10/1948  
that I last saw her alive on 3/10/1948 and that death occurred on the date and hour stated above.  
Immediate cause of death: generalized arteriosclerosis Duration 24 hrs

8. AGE: Years Months Days If less than one day  
1 hr. min.  
9. Birthplace St. Charles Missouri  
(City, town, or county) (State or foreign country)

Due to Prematurity  
Due to \_\_\_\_\_  
Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_  
Major findings: Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

MOTHER FATHER

11. Industry or business \_\_\_\_\_  
12. Name Myron Alvin Crossman  
13. Birthplace Webster Groves Missouri  
14. Maiden name Audrey Delores Carver  
15. Birthplace St. Louis Missouri  
16. (a) Informant Myron Crossman  
(b) Address 2429 Oakland  
17. (a) Burial (b) Date thereof 3/11/48  
(c) Place: burial or cremation Mount Lebanon Cemetery  
18. (a) Signature of funeral director Collins Funeral Home  
(b) Address 10173 St. Charles Rd.  
19. (a) Date received local registrar March 12-48 (Registrar's signature) \_\_\_\_\_

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? \_\_\_\_\_  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_  
While at work? \_\_\_\_\_ Means of injury \_\_\_\_\_  
23. Signature Walter C Gray (M. D. or other) M.D.  
Address 3209 Brown Rd. Date signed 3/10/48

PHYSICIAN  
Underline the cause to which death should be charged statistically.

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed MAR 18 1948

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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.....

*Not embalmed*....., Registered Apprentice No.....  
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.