

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

6079

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

#88751

318

1003

Registrar's No. 1949

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_

15

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) OR <b>St. Louis, Mo.</b> TOWN		c. CITY (If outside corporate limits, write RURAL and give township) OR <b>St. Louis</b> TOWN	
d. FULL NAME OF HOSPITAL OR INSTITUTION: <b>St. Louis City Hospital #1.</b>		d. STREET ADDRESS (If rural, give location) <b>5000 Alabama Ave.,</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b> b. (Middle) <b>F.</b> c. (Last) <b>CRANDALL</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Feb. 27, 1949</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Aug. 11, 1874</b>
9. AGE (In years last birthday) <b>74</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>16</b>	IF UNDER 24 HRS. Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Indiana</b>
12. CITIZEN OF WHAT COUNTRY?			
13a. FATHER'S NAME <b>Jacob Crandall</b>		13b. MOTHER'S MAIDEN NAME <b>Effie Brewer</b>	14. NAME OF HUSBAND OR WIFE <b>Bessie Crandall</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT'S SIGNATURE OR NAME <b>Mrs. Bessie Crandall</b> ADDRESS <b>5000 Alabama Ave.,</b>
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* <b>(a) Cardiac tamponade</b> <b>(b) Rupture of rt. aortic</b> <b>(c) Arteriosclerosis of coronary artery</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b> <b>5 min.</b> <b>10 yrs.</b>	
II. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c)		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>2/8/49</b> , 19___, to <b>2/27/49</b> , 19___, that I last saw the deceased alive on <b>2/27/49</b> , 19___, and that death occurred at <b>12:20A m.</b> , from the causes and on the date stated above.			
23a. SIGNATURE <b>William W. Carter M.D.</b>		23b. ADDRESS <b>1515 Lafayette Ave.,</b>	23c. DATE SIGNED <b>2/28/49</b>
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>3-1-49</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Sunset Burial Park</b>	24d. LOCATION (City, town, or county) (State) <b>St. Louis County Mo.</b>
DATE REC'D BY LOCAL REG. <b>MAR 1 1949</b>	REGISTRAR'S SIGNATURE <b>J. B. Lasater</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>Southern Funeral Home</b> <b>6322 S. Grand Blvd.,</b>	ADDRESS

**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 \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Signed David J. Fossan.

Signed \_\_\_\_\_  
Student Embalmer

Licensed Embalmer No. 4242.

P. O. Address 6322 So Grand

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.