S. No. 300
EV. 10.48

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

FILED SEP 24 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 31692

BIRTH NO. 60441 - 49 REG. DIST. NO. 318 PRIMARY REG. DIST. No. 1003 Registrar's No. 8009

1. PLACE OF DEATH
a. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Louis
c. LENGTH OF STAY (In this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): De Paul Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Missouri
b. COUNTY: St. Louis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mol ine
d. STREET ADDRESS (If rural, give location): 2112 Nemnich

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Delbert
c. (Last): Crowe

4. DATE OF DEATH (Month) (Day) (Year): Sept 13th, 1949

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: sept .11th1949
9. AGE (In years last birthday): IF UNDER 1 YEAR Months: Days: 2; IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Louis
12. CITIZEN OF WHAT COUNTRY?:

13a. FATHER'S NAME: George D. Crowe
13b. MOTHER'S MAIDEN NAME: Irene Abernathy
14. NAME OF HUSBAND OR WIFE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S SIGNATURE OR NAME: Geo. D. Crowe, 2112 Nemnich
ADDRESS:

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, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity. — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cause unknown.
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 [X] NO [ ]

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): 154
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: 776X

22. *I hereby certify that I attended the deceased from* 9/11, 1949, *to* 9/13, 1949, *that I last saw the deceased alive on* 9/13, 1949, *and that death occurred at* 11. a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. O. Mourey (Degree or title): M. D.
23b. ADDRESS: 3625 Fair Oaks
23c. DATE SIGNED: 9/15/49

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/16/49 Sept. 16th
24c. NAME OF CEMETERY OR CREMATORY: Memorial Park Cemetery
24d. LOCATION (City, town, or county) (State): St. Louis, Mo.

DATE REC'D BY LOCAL REG.: SEP 15 1949
REGISTRAR'S SIGNATURE: J B Lasater
25. FUNERAL DIRECTOR'S SIGNATURE: Diedrich F. Home
ADDRESS: 8319 Hallsferry

(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 _____

_____, Student Embalmer No. _____,

working under my personal supervision.

Signed Arthur R. Liedner

Signed _____
Student Embalmer

Licensed Embalmer No. 3556

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.