

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

38615

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

FILED NOV 21 1949

1003

Registrar's No. 9592

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. _____		Registrar's No. 9592	
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give town or township) <u>St. Louis</u>		c. LENGTH OF STAY (in this place) <u>7mo-3da</u>		c. CITY (If outside corporate limits, write RURAL and give township) <u>St. Louis</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>St. Louis Children's Hospital</u>				d. STREET ADDRESS (If rural, give location) <u>94214a No. Broadway</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>LINDA</u>		b. (Middle) <u>Sue</u>		c. (Last) <u>CREMEENS</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov. 6 - 1949</u>	
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>child</u>		8. DATE OF BIRTH <u>Feb-9-1948</u>	
9a. 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) <u>St. Louis - Mo. 0</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>Edward F. Cremeens</u>			13b. MOTHER'S MAIDEN NAME <u>Gladys Cochrane</u>			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) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Edward Cremeens</u> ADDRESS <u>4214a N. Broadway</u>			
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, ashenia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Tuberculous Meningitis</u>  ANTECEDENT CAUSES <u>Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.</u>  DUE TO (b) _____  DUE TO (c) _____  II. OTHER SIGNIFICANT CONDITIONS <u>Conditions contributing to the death but not related to the disease or condition causing death.</u>				INTERVAL BETWEEN ONSET AND DEATH _____	
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" 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) <u>12</u>			
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? <u>002X</u>			
22. I hereby certify that I attended the deceased from <u>4-3 1949</u> , to <u>11-6 1949</u> , that I last saw the deceased alive on <u>11-6 1949</u> , and that death occurred at <u>2 P. m.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Wm. G. Klingberg M.D.</u>				23b. ADDRESS <u>2145 Princeton</u>		23c. DATE SIGNED <u>Nov. 6, 1949</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov. 8, 1949</u>		24c. NAME OF CEMETERY OR CREMATORY <u>Friedens Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>St. Louis, MO.</u>	
DATE REC'D BY LOCAL REG. <u>NOV 7 1949</u>		REGISTRAR'S SIGNATURE <u>J. B. Jasata</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Suedmeyer &amp; Son's 3934 N. 20 Street</u>			

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

**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.

Student .....  
Student Embalmer

Signed *Neville D. Frohwitter*

Licensed Embalmer No. *3696*

P. O. Address *3934 N 20th*

**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.