

FILED AUG 10 1950

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **24666**
Registrar's No. **6535**

BIRTH NO. _____ REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Mo. b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St Louis		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis	
c. LENGTH OF STAY (In this place)		3 119	
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION Alexian Bros. Hospital		d. STREET ADDRESS (If rural, give location) 3720 Lincoln Ave	

3. NAME OF DECEASED (Type or Print) Claude Crozier			4. DATE OF DEATH (Month) (Day) (Year) July 30 1950		
a. (First)	b. (Middle)	c. (Last)	5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Aug. 5 1877	9. AGE (In years last birthday) (Specify) 72	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) France	12. CITIZEN OF WHAT COUNTRY?

13a. FATHER'S NAME Claude Crozier		13b. MOTHER'S MAIDEN NAME Madeline Joubard		14. NAME OF HUSBAND OR WIFE Amelia Crozier	
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. none		17. INFORMANT'S SIGNATURE OR NAME ADDRESS Amelia Crozier 3720 Lincoln Ave.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)		MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)		<i>Heart attack</i>		<i>about</i>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<i>hypertension</i>		<i>2 years</i>	
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		DUE TO (b)			
		DUE TO (c)			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input 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) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 103X	
22. I hereby certify that I attended the deceased from Jan 10, 1950 , to July 30, 1950 , that I last saw the deceased alive on July 30, 1950 , and that death occurred at 11:55 a.m. , from the causes and on the date stated above.					

23a. SIGNATURE <i>[Signature]</i>		(Degree or title)		23b. ADDRESS 3606 Adams	
23c. DATE SIGNED 7/31/50		24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 8/2/50	
24c. NAME OF CEMETERY OR CREMATORY Mount Carmel Cemetery		24d. LOCATION (City, town, or county) (State) Belleville Ill.			

DATE REC'D BY LOCAL REG. JUL 31 1950		REGISTRAR'S SIGNATURE <i>[Signature]</i>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Sullivan Funeral Dir. 2849 N. Euclid	
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

4111

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.....

.....
working under my personal supervision.

Signed.....
Student Embalmer

Student Embalmer No.....
Signed *Robert L. Brinkman*
Licensed Embalmer No. *3553*
P. O. Address *St. Louis Mo*

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.