

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

17963

FILED MAY 17 1951

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State File No.

4385
Registrar's No.

BIRTH NO. _____		REG. DIST. NO. _____		PRIMARY REG. DIST. NO. _____		State File No.	
1. PLACE OF DEATH a. COUNTY St. Louis - Mo				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Missouri b. COUNTY _____			
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis		c. LENGTH OF STAY (In this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis		2109	
d. FULL NAME OF HOSPITAL OR INSTITUTION James E. Crow 4358 Labadie				d. STREET ADDRESS (If rural, give location) 4358 Labadie Ave			
3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) E. c. (Last) Crow			4. DATE OF DEATH (Month) (Day) (Year) May 7 1951				
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single		8. DATE OF BIRTH January 15 1901	
9. AGE (In years last birthday) 50		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri	
12. CITIZEN OF WHAT COUNTRY? Yes		13a. FATHER'S NAME William Crow		13b. MOTHER'S MAIDEN NAME Letha Howard		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 Mrs Georgia Parker ADDRESS 4358 Labadie			
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.		I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medical Insufficiency ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 wks	
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 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 H/OX			
22. I hereby certify that I attended the deceased from 5/7 1951 , to 5/7 1951 , that I last saw the deceased alive on 5/6 1951 , and that death occurred at 6:45 a.m. , from the causes and on the date stated above.							
23a. SIGNATURE (Type or Print) Orville B. Easton				23b. ADDRESS 4324th Easton		23c. DATE SIGNED 5/8-51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE 5-9-51		24c. NAME OF CEMETERY OR CREMATORY Oak Grove		24d. LOCATION (City, town, or county) (State) St. Charles Mo	
DATE REC'D BY LOCAL REG. MAY 9 1951		REGISTRAR'S SIGNATURE J. B. Laster		25. FUNERAL DIRECTOR'S SIGNATURE Herman J. Smith		ADDRESS 4247/w Laba	

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 _____

working under my personal supervision.

Student Embalmer No. 414

Signed Leonard H. Grant
Student Embalmer

Signed Lawrence Edvardson

Licensed Embalmer No. 4341

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.