

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

1003.

State File No. ....

42856

11089

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. _____		Registrar's No. _____			
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)					
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>ST. LOUIS, MO.</b>		c. LENGTH OF STAY (In this place)		a. STATE <b>Missouri</b>		b. COUNTY <b>Crawford</b>			
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>BARNES HOSPITAL</b>				c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>Leasburg</b>		0280			
d. STREET ADDRESS (If rural, give location) <b>/</b>									
3. NAME OF DECEASED (Type or Print)			a. (First)		b. (Middle)		c. (Last)		
JAMES			J.		GRESSWELL		4. DATE OF DEATH (Month) (Day) (Year)		
Dec			14.		1951				
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>Mar 18.1876</b>		9. AGE (In years last birthday) <b>75</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Leasburg Mo</b>				12. CITIZEN OF WHAT COUNTRY?	
13a. FATHER'S NAME <b>George Cresswell</b>			13b. MOTHER'S MAIDEN NAME <b>Mary Ray</b>			14. NAME OF HUSBAND OR WIFE <b>Mazie Cresswell</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>Unk</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Paul Lee 4136 Mc Pherson</b>				
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) <b>Cerebral Embolism</b>		II. OTHER SIGNIFICANT CONDITIONS						-	
*This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.		ANTECEDENT CAUSES						-	
		Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.							
		DUE TO (b) <b>Arteriosclerotic heart disease</b>							
		DUE TO (c)							
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)					
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? <b>4200</b>					
22. I hereby certify that I attended the deceased from <b>11-21-</b> , 19 <b>51</b> , to <b>12-11-</b> , 19 <b>51</b> , that I last saw the deceased alive on <b>12-11-</b> , 19 <b>51</b> , and that death occurred at <b>5:25 p. m.</b> , from the causes and on the date stated above.									
23a. SIGNATURE (Degree or title) <b>Boyer G. Waller M.D.</b>				23b. ADDRESS <b>BARNES HOSPITAL</b>				23c. DATE SIGNED <b>12-11-51</b>	
24a. BURIAL, CREMA NON-REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>12-15-51</b>		24c. NAME OF CEMETERY OR CREMATORY		24d. LOCATION (City, town, or county) (State) <b>Leasburg Mo</b>			
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>DEC 15 1951</b>				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Albert H. Hoppe 4700 Washington</b>					

(Licensed Embalmer's Statement on Reverse Side)

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

NOV 26 1952

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 *John J. Haines* \_\_\_\_\_

Licensed Embalmer No. *4108*

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.