

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **22787**
5513

FILED JUN 20 1953
BIRTH NO. **38779** - REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **5513**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN St. Louis		a. STATE Missouri	b. COUNTY St. Louis
c. LENGTH OF STAY (in this place) 0		c. CITY OR TOWN St. Ann's	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION Jewish Hospital		e. STREET ADDRESS (If rural, give location) Route 7, Box 629a	

3. NAME OF DECEASED (Type or Print)	a. (First) Baby	b. (Middle)	c. (Last) Crawford	4. DATE OF DEATH (Month) (Day) (Year)
				May 31, 1953

5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married	8. DATE OF BIRTH May 30, 1953	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 2 HRS. Hours	Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Mo.		12. CITIZEN OF WHAT COUNTRY? U.S.		

13a. FATHER'S NAME William Crawford Jr.	13b. MOTHER'S MAIDEN NAME Georgia Radford	14. NAME OF HUSBAND OR WIFE None
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT'S SIGNATURE OR NAME William Crawford Jr., Rt. 7 Box 629a	ADDRESS St. Ann's, Mo.
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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) Prematurity		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ 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 <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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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)
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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? 776X
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22. I hereby certify that I attended the deceased from **May 30, 1953**, to **May 31, 1953** that I last saw the deceased alive on **May 31, 1953**, and that death occurred at **5:10 a. m.**, from the causes and on the date stated above.

23a. SIGNATURE Paul K. Webb (Degree or title) MD	23b. ADDRESS 721 Olive St.	23c. DATE SIGNED 6-2-53
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal	24b. DATE 6-2-53	24c. NAME OF CEMETERY OR CREMATORY Laurel Hill Gardens	24d. LOCATION (City, town, or county) (State) St. Louis Co., Mo.
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DATE REC'D BY LOCAL REG. JUN 2 1953	REGISTRAR'S SIGNATURE [Signature]	25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	ADDRESS 4700 Washington Blvd.
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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.....
Signature of Student Embalmer

Signed.....
Licensed Embalmer No.....

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.