

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED AUG 12 1953

State File No. **26242**
Registrar's No. **6868**

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

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|---|--|--|------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before death.) a. STATE Missouri b. COUNTY St. Louis | | | |
| b. CITY (If outside corporate limits, write RURAL and give OR TOWN ST. LOUIS, MISSOURI) | | c. LENGTH OF STAY (in this place) | c. CITY OR TOWN Lemay | | d. Is residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/> |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BARNES HOSPITAL | | | | | |
| e. STREET ADDRESS (If rural, give location) 2808 Telegraph Road #860 | | | | | |

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|---|-----------------------|--------------------------|------------------------|-------------------------|-------------------|-----------------|------------------|
| 3. NAME OF DECEASED (Type or Print) | a. (First) ArL | b. (Middle) White | c. (Last) Cross | 4. DATE OF DEATH | (Month) 7/ | (Day) 12 | (Year) 53 |
|---|-----------------------|--------------------------|------------------------|-------------------------|-------------------|-----------------|------------------|

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|------------------------------|---|---|---|--|------------------------|----------------------|-------|------|
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Nov. 16, 1903 | 9. AGE (In years last birthday) 49 | IF UNDER 1 YEAR Months | IF UNDER 4 HRS. Days | Hours | Min. |
|------------------------------|---|---|---|--|------------------------|----------------------|-------|------|

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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher | 10b. KIND OF BUSINESS OR INDUSTRY Packing Company | 11. BIRTHPLACE (City and State or Foreign Country) Kentucky | 12. CITIZEN OF WHAT COUNTRY? USA |
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| 13a. FATHER'S NAME John Cross | 13b. MOTHER'S MAIDEN NAME Iona True | 14. NAME OF HUSBAND OR WIFE Ruth Cross |
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| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No | 16. SOCIAL SECURITY NO. Yes | 17. INFORMANT'S SIGNATURE OR NAME Ruth Cross, 2808 Telegraph Rad, | ADDRESS Lemay, Mo. |
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| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) <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.</i> | MEDICAL CERTIFICATION | | INTERVAL BETWEEN ONSET AND DEATH 16-18 HRS |
| | I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL EMBOLUS | | |
| | 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. | | MITRAL STENOSIS RHEUMATIC HEART DISEASE, INACTIVE | |

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| 19a. DATE OF OPERATION 7/11/53 | 19b. MAJOR FINDINGS OF OPERATION MITRAL VALVULOTOMY | 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) 332X | (COUNTY) | (STATE) |
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| | | |
|---|--|-----------------------------------|
| 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? |
|---|--|-----------------------------------|

22. I hereby certify that I attended the deceased from 7 - 6, 1953, to 7 - 12, 1953, that I last saw the deceased alive on 7/12, 1953, and that death occurred at 2:20 pm., from the causes and on the date stated above.

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| 23a. SIGNATURE John J. McDonald | (Degree or title) M. D. O. | 23b. ADDRESS BARNES HOSPITAL | 23c. DATE SIGNED 7/12/53 |
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| 24a. BURIAL, CREMATION, REMOVAL (Specify) Removal | 24b. DATE 7-13-53 | 24c. NAME OF CEMETERY OR CREMATORY Odd Fellows | 24d. LOCATION (City, town, or county) (State) Charleston, Missouri |
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| DATE REC'D BY LOCAL REG. JUL 13 1953 | REGISTRAR'S SIGNATURE Healy Smith MD | 25. FUNERAL DIRECTOR'S SIGNATURE McLaughlin Funeral Home, | ADDRESS 2301 Lafayette, St. Louis, 4, Missouri |
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(Licensed Embalmer's Statement on Reverse Side)

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 *James R. Chapman*

Licensed Embalmer No. *45*

P. O. Address *St. Louis*

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.