

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **29880**  
Registrar's No. **7687**

FILED AUG 31 1953

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>7687</b>		
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <b>Missouri</b> b. COUNTY _____				
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) _____		c. CITY OR TOWN <b>St. Louis</b>		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: <b>Homer G. Phillips</b>				e. STREET ADDRESS (If rural, give location) <b>2501 Goode</b>				
3. NAME OF DECEASED (Type or Print) a. (First) <b>Joyce</b> b. (Middle) _____ c. (Last) <b>Crouch</b>			4. DATE OF DEATH (Month) (Day) (Year) <b>8 1 53</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) <b>Never Married</b>		8. DATE OF BIRTH <b>April 1, 1945</b>		
9. AGE (In years last birthday) <b>8</b>		IF UNDER 1 YEAR Months <b>4</b>		IF UNDER 1 YEAR Days _____		IF UNDER 1 YEAR Hours _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>St. Louis, Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13a. FATHER'S NAME <b>Joseph Crouch</b>			13b. MOTHER'S MAIDEN NAME <b>Hazel Neece</b>			14. NAME OF HUSBAND OR WIFE <b>Nil</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Hazel Crouch</b> ADDRESS <b>1525 Goode Ave</b>			
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, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Extreme Malnutrition</b> <b>Dehydration</b> 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 <b>Undt.</b>	
		II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Miliary Tuberculosis</b> <b>Cerebral Palsy</b>						
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) _____		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 <b>7-21, 1953</b> , to <b>8-1, 1953</b> , that I last saw the deceased alive on <b>8-1, 1953</b> , and that death occurred at <b>4:50 Pm.</b> , from the causes and on the date stated above.								
23a. SIGNATURE <b>J. Ferreira</b> (Degree or title) <b>M.D.</b>				23b. ADDRESS <b>2601 N. Whittier</b>		23c. DATE SIGNED <b>8-4-53</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>8/6/53</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Washington Park</b>		24d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo</b>		
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>AUG 6 1953</b>		REGISTRAR'S SIGNATURE <b>Carl Smith M.D.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>B. France</b> ADDRESS <b>1221 N. Grand</b>				

Carried with C.D.C. as 77B. pp.

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

(Licensed Embalmer's Statement on Reverse Side)

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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..... *Huyton Swan*

Licensed Embalmer No. *4580*

P. O. Address *1221 W. Genoa*

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.