

STANDARD CERTIFICATE OF DEATH

State File No. **20346**

FILED JUN 24 1954

BIRTH NO. **7104-54** REG. DIST. NO. **318** PRIMARY REG. DIST. NO. **1003** Registrar's No. **4885**

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY Boone	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis, Mo. 2		c. LENGTH OF STAY (in this place) 1 mo - 10 da	c. CITY OR TOWN Columbia
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis Childrens		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>	
e. STREET ADDRESS (If rural, give location) 1301 Lakeview			

3. NAME OF DECEASED (Type or Print) Debra Ann Critchfield			4. DATE OF DEATH (Month) (Day) (Year) 5-31-54		
a. (First)	b. (Middle)	c. (Last)			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married	8. DATE OF BIRTH 2-21-54		9. AGE (In years last birthday) 3 10. MONTHS 10 11. DAYS 10
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) Columbia, Mo	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					

13a. FATHER'S NAME Howard Critchfield		13b. MOTHER'S MAIDEN NAME Dorothy Turner		14. NAME OF HUSBAND OR WIFE none	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO. Nil.		17. INFORMANT'S SIGNATURE OR NAME H. Johnston	
				ADDRESS 500 So Kingshighway	

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) Constriction of the aorta - infantile type		DUE TO (b) _____			3 mos 10 days
DUE TO (c) _____		II. OTHER SIGNIFICANT CONDITIONS			
*This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		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) 754.5	
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 **4-21-1954**, to **5-31-1954**, that I last saw the deceased alive on **5-31-1954**, and that death occurred at **7 a m.**, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Hulda J. Woltman, M.D.		23b. ADDRESS 500 So. Kingshighway		23c. DATE SIGNED 6-1-54	
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24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 6-2-54		24c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery Columbia, Mo.	
				24d. LOCATION (City, town, or county) (State)	

DATE REC'D BY LOCAL REG. JUN 2 1954		REGISTRAR'S SIGNATURE J. Carl Smith		25. FUNERAL DIRECTOR'S SIGNATURE Albert H. Hoppe	
				ADDRESS 4700 Washington	

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 prepared by me, or by, Student Embalmer No..... working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed *Lawrence G. Mott*
Res. Embalmer

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. 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.