

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

XC # 156 23 00
REG # 6223
SL # 4487
BIRTH NO.

REG. DIST. NO. 318 PRIMARY REG. DIST. NO. 1003 Registrar's No. 0882

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

1. PLACE OF DEATH a. COUNTY <u>0</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>MISSOURI</u> b. COUNTY		
b. CITY (If outside corporate limits, write RURAL and give town) <u>915 N. GRAND, ST. LOUIS, MO.</u>		c. LENGTH OF STAY (In this place) <u>3 DAYS</u>	c. CITY OR TOWN <u>ST. LOUIS</u>		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 <u>VETERANS ADMINISTRATION HOSP.</u>			STREET ADDRESS (If rural, give location) <u>5865 CATES</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>ROY</u>		b. (Middle) <u>FRANCIS</u>	c. (Last) <u>CROSON</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1-29-55</u>	
5. SEX <u>MALE 0</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>9-9-89</u>	9. AGE (In years last birthday) <u>65</u>	IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>CABINET MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>DOWNING, MISSOURI 0</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13a. FATHER'S NAME <u>CHARLES CROSON</u>		13b. MOTHER'S MAIDEN NAME <u>JULIA MC CONNELL</u>
14. NAME OF HUSBAND OR WIFE <u>EDNA CROSON</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES WWI</u>		
16. SOCIAL SECURITY NO. <u>494-01-2608</u>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>VA HOSPITAL RECORDS, ST. LOUIS, MISSOURI</u>			
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, asthenia, etc. It means the disease, injury, or complication which caused death.			MEDICAL CERTIFICATION		
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>ACUTE NECROTIZING PANCREATITIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u>		
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 <u>CHRONIC CHOLECYSTITIS</u> Conditions contributing to the death but not related to the disease or condition causing death. <u>ARTERIOSCLEROTIC HEART DISEASE</u>		
5 YEARS 3 YEARS			19a. DATE OF OPERATION		
19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) (Minute) <u>VA</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>5872</u>		
22. I hereby certify that I attended the deceased from <u>1-26-55</u> , 19 <u>55</u> , to <u>1-29-55</u> , 19 <u>55</u> , that he last was seen <u>alive on</u> <u>1-29-55</u> and that death occurred at <u>8:00 Am.</u> , from the causes and on the date stated above.					
23a. SIGNATURE <u>William E. Lucas, M.D.</u> <u>WILLIAM E. LUCAS</u>			23b. ADDRESS <u>VAH, ST. LOUIS, MISSOURI</u>		23c. DATE SIGNED <u>1-29-55</u>
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		24b. DATE <u>2/1/55</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Memorial Park Cem.</u>	24d. LOCATION (City, town, or county) (State) <u>St. Louis County Mo.</u>	
DATE REC'D BY LOCAL REG. <u>JAN 31 1955</u>		REGISTRAR'S SIGNATURE <u>J. Earl Smith, M.D.</u>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Drehmann-Harral 1905 Union Blvd.</u>		

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.....
Albert R. Thompson Jr.

Licensed Embalmer No. *4257*

P. O. Address *H. D. ...*

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.