

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

34685

FILED OCT 24 1955

State File No. \_\_\_\_\_  
Registrar's No. **8755**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>		Registrar's No. <b>8755</b>			
1. PLACE OF DEATH a. COUNTY _____				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b>				b. COUNTY _____	
b. CITY (If outside corporate limits, write RURAL and give town(ship)) OR TOWN <b>St. Louis</b>			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN <b>Chester</b>		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>		
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Mo. Baptist Hospital</b>				e. STREET ADDRESS (If rural, give location) _____				<b>8128</b>	
3. NAME OF DECEASED (Type or Print) a. (First) <b>CHARLES</b>			b. (Middle) _____		c. (Last) <b>DE CROW</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>10-5-55</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>		8. DATE OF BIRTH <b>8-20-1903</b>		9. AGE (In years last birthday) <b>52</b>	
IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 1 YEAR Days _____ Hours _____ Min. _____		IF UNDER 1 YRS. Hours _____ Min. _____					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>drug salesman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Drug</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Cairo, Ill.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13a. FATHER'S NAME <b>unknown</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>			14. NAME OF HUSBAND OR WIFE <b>EVELYN DE CROW</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unknown</b>			16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>Evelyn DeCrow, Chester, Ill.</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, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Aneurysm, basilar anterior cerebral artery legs.</b> ANTECEDENT CAUSES <b>Morbid conditions, if any, giving rise to the above cause (a), stating the underlying cause last.</b> DUE TO (b) <b>Hemorrhage, subarachnoid</b> DUE TO (c) <b>Spontaneous rupture</b> II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. <b>330x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
19a. DATE OF OPERATION <b>10-4-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>Aneurysm leg Ant. cerebral, filling right frontal lobe area</b>						20. AUTOPSY? YES <input 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) (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 <b>10-1-</b> , 19 <b>55</b> , to <b>10-5</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>10-5</b> , 19 <b>55</b> , and that death occurred at <b>5:05 P.M.</b> , from the causes and on the date stated above.									
23a. SIGNATURE <b>George E. Lombard</b> (Degree or title) _____				23b. ADDRESS <b>no 3720 Washington Ave</b>			23c. DATE SIGNED <b>10-6-55</b>		
24a. BURIAL, CREMATION, REMOVAL (Specify) _____		24b. DATE <b>10-6-55</b>		24c. NAME OF CEMETERY OR CREMATORY _____		24d. LOCATION (City, town, or county) (State) <b>MOUND CITY, ILLINOIS</b>			
DATE REC'D BY LOCAL REG. <b>OCT 7 1955</b>		REGISTRAR'S SIGNATURE <b>J. Carl Smith</b>			25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>ALSTAT FUNERAL HOME, MOUND CITY ILL</b>				

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 emb

by me, or by ..... Student Embalmer No.....

working under my personal supervision..

Student.....  
Signature of Student Embalmer

Signed *Ben Hoffman*.....

Licensed Embalmer No. *43*.....

P. O. Address *St. Louis*.....

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