

Health, Welfare Public Service

300 1-56

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

STANDARD CERTIFICATE OF DEATH

24920

FILED JUL 20 1956

41123-56

Registration District No.

318

Primary Registration District No.

1003

STATE FILE NUMBER

6058

Registrar's No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>INDIANAPOLIS, IND.</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MISSOURI</b>		c. CITY OR TOWN <del>ST. LOUIS, MISSOURI</del> <b>INDIANAPOLIS, IND.</b>	
c. FULL NAME OF (Hospital, etc.) <b>ST. LOUIS CITY HOSPITAL #1.</b>		d. STREET ADDRESS <b>140 SO. CATHERWOOD, INDIANAPOLIS, IND.</b>	
3. NAME OF DECEASED (Type or print) <b>ANGLINA <sup>First</sup> ELIZABETH <sup>Middle</sup> CROCKETT <sup>Last</sup></b>		4. DATE OF DEATH <b>JUNE 9, 1956</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JUNE 9, 1956</b>
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>	9. AGE (In years last birthday) <b>0</b>
11. BIRTHPLACE (City and state or country) <b>ST. LOUIS, MISSOURI</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RALPH CROCKETT</b>		14. MOTHER'S MAIDEN NAME <b>VIRGINIA FOSTER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ST. LOUIS CITY HOSPITAL RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a. m. p. m.			
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from <b>6/9/56</b> to <b>6/9/56</b> and last saw her alive on <b>6/9/56</b> Death occurred at <b>7:45 AM</b> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <b>Paul M. Smith, M.D.</b> (Degree or title)		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>6/12/56.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6-30-56</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Anatomical Board</b>		23d. LOCATION (City, town, or county) (State) <b>St. Louis, Mo.</b>	
24. FUNERAL DIRECTOR <b>Rowland-Aker Mortuary Service</b> ADDRESS <b>414 Manchester Ave. St. Louis 10, Mo.</b>		25. DATE RECD. BY LOCAL REG. <b>JUN 27 1956</b>	
26. REGISTRAR'S SIGNATURE <b>Paul Smith M.D.</b>			

STATE OF TEXAS  
 DEPARTMENT OF HEALTH  
 DIVISION OF PUBLIC HEALTH  
 EMBALMERS' BOARD  
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 DIVISION OF PUBLIC HEALTH  
 EMBALMERS' BOARD

**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.....

Licensed Embalmer No.....

P. O. Address.....

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.