

FILED MAY 20 1957

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

18561

STATE FILE NUMBER

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4147**

1. PLACE OF DEATH a. COUNTY			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR St. Louis TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Wellston 4311		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 16 Mo. Baptist Hospital		Length of stay in 1b 8 weeks	d. STREET ADDRESS (If outside, give location) 27 6204 Julian Avenue		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ELMER Middle CHARLES Last CRAWFORD			4. DATE OF DEATH Month April Day 30 Year 1957		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 29, 1897	9. AGE (In years last birthday) 59	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Wellston School Dist	11. BIRTHPLACE (City and state or country) St. Louis, Missouri	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Crawford			14. MOTHER'S MAIDEN NAME Grace Burnham		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes World War 1		16. SOCIAL SECURITY NO. 488-28-3377	17. INFORMANT Address Mrs. Edna Crawford, 6204 Julian Avenue.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Cecum Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) metastases to regional nodes DUE TO (c) Peritonitis from Carcinoma 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 8 mo ? ?
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 Feb 10 1957 to April 30, 1957 and last saw her 3:50 A. m on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE (Degree or title) Dominic J Verducci M.D.			22b. ADDRESS 45000 lie		22c. DATE SIGNED 5-1-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE May 2, 1957	23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery		23d. LOCATION, (City, town, or county) (State) St. Louis County, Missouri.
24. FUNERAL DIRECTOR Shepard Funeral Home, 1167 Hamilton Ave			25. DATE RECD. BY LOCAL REG. MAY 1 '57	26. REGISTRAR'S SIGNATURE J. Carl Smith M.D.	

(Licensed Embalmer's Statement on Reverse Side)

300
1-56

All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes. Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE.

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 *John L. Demmer*

Licensed Embalmer No. *419*

P. O. Address *St. Louis*

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.