

pt. Health,  
, & Welfare  
S. Public  
alth Service

THE DIVISION OF HEALTH OF MISSOURI  
**STANDARD CERTIFICATE OF DEATH**

41833

STATE FILE NUMBER

FILED DEC 10 1957

Registration District No. **318** Primary Registration District No. **1003** Registrar No. **11451**

S. 300  
ev. 1-57

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>ST. LOUIS, MO.</b>		c. CITY OR TOWN <b>St. Louis</b>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>ST. LOUIS CITY HOSP. #1.</b>		d. STREET ADDRESS (If outside, give location) <b>2237 1003 Park</b>	
3. NAME OF DECEASED (Type or print) First <b>RAYMOND</b> Middle <b>C.</b> Last <b>CARROLL</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>25,</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4-5-1888</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Poultry Tect.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	9. AGE (In years last birthday) <b>69</b> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (City and state or country) <b>Indiana</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13a. FATHER'S NAME <b>Delta Carroll</b>		13b. MOTHER'S MAIDEN NAME <b>Amanda Bennett</b>	
14. NAME OF HUSBAND OR WIFE <b>Bertha Crowder, Arcadia, Indiana</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>494-24-1596</b>		17. INFORMANT <b>Bertha Crowder, Arcadia, Indiana</b>	
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>HEPATIC COMA</b> DUE TO (b) <b>ASTRO-INTESTINAL HEMORRHAGE</b> DUE TO (c) <b>CIRRHOSIS OF LIVER</b> 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
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		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.) <b>581.0</b>		20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.	
20d. INJURY OCCURRED WHILE AT <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>11/21/57</b> to <b>11/25/57</b> and last saw her/him alive on <b>11/25/57</b> Death occurred at <b>4:25 P.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Albert E. Kozlowski M.D.</b>		22b. ADDRESS <b>1515 LAFAYETTE AVE.</b>	
22c. DATE SIGNED <b>11/26/57</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	
23b. DATE <b>11-29-1957</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Trinity Luthern</b>	
23d. LOCATION (City, town, or county) (State) <b>St. Louis County, Mo.</b>		24. FUNERAL DIRECTOR <b>McLaughlin's, 2301 Lafayette</b>	
25. DATE RECD. BY LOCAL REG. <b>NOV 29 57</b>		26. REGISTRAR'S SIGNATURE <b>J. Carl Smith, M.D.</b>	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 *A. G. Jarvis* .....

Licensed Embalmer No. *3384*  
P. O. Address *St. Louis*

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.