

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED NOV 27 1957

STATE FILE NUMBER
41874
11060

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

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 01 3973 West Belle		d. STREET ADDRESS (If outside, give location) 211 3973 West Belle Pl.	
3. NAME OF DECEASED (Type or print) First Middle Last Fannie Crockett		4. DATE OF DEATH Month Day Year Nov. 16, 1957	
5. SEX 3 Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 28, 1891
9. AGE (In years last birthday) 66		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-wife		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (City and state or country) Mobile, Alabama
13. FATHER'S NAME John Richardson		12. CITIZEN OF WHAT COUNTRY? USA	
14. MOTHER'S MAIDEN NAME Caroline Smith		17. INFORMANT Address Bessie Marshall 3973 West Belle Pl.,	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardiac Disease Arteriosclerosis Senility DUE TO (b) Arteriosclerosis DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(n)			INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		443	
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 1952 29:30 Nov 16, 1957 and last saw her alive on Nov 15, 1957 Death occurred at 4:30 a. m. on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE R. C. Haskell M.D.		22b. ADDRESS 1303 N. Kingshighway	22c. DATE SIGNED 11-18-57
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 11/21/57	23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery	23d. LOCATION (City, town, or county) (State) St. Louis County, Mo.,
24. FUNERAL DIRECTOR Swan Und. Co.,	ADDRESS 4481 Finney Ave.	25. DATE RECD. BY LOCAL REG. NOV 19 57	26. REGISTRAR'S SIGNATURE J. Carl Smith, M.D. S.P.

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 *Leroy U. Bannister*

Licensed Embalmer No. *452*

P. O. Address *4251 Wood*

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.