

Health, Welfare Public Service

FILED JAN 23 1958

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

STATE FILE NUMBER **2789**
476
Registrar's No.

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

300
1-57

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 Homer G. Phillips		d. STREET ADDRESS (If outside, give location) 4462 Cook	
3. NAME OF DECEASED (Type or print) First Nannie Middle Crawford Last		4. DATE OF DEATH Month 1 Day 11 Year 58	
5. SEX 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 10-15-9
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		11. BIRTHPLACE (City and state or country) Birmingham Ala	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13a. FATHER'S NAME not known		14. NAME OF HUSBAND OR WIFE Louise Crawford	
13b. MOTHER'S MAIDEN NAME not known		17. INFORMANT Louise Crawford Address 4462 Cook	
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. no	
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 Transverse Colon			INTERVAL BETWEEN ONSET AND DEATH undet.
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) 153.1			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Multiple Polyps of Colon - Left Ovary Leiomyoma			19. WAS AUTOPSY PERFORMED? 2 YES <input type="checkbox"/> NO <input checked="" 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.)	
20c. TIME OF INJURY Hour _____ 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 11-2-57 to 1-11-58 and last saw her alive on 1-11-58 Death occurred at 2:10 A m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) Jones M. Albert, M.D.		22b. ADDRESS 2601 Whittier Street	
22c. DATE SIGNED 1-11-58			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE 1-15-58	
23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION (City, town, or county) (State) St. Louis, Mo.	
24. FUNERAL DIRECTOR A. L. Beal and Son ADDRESS 4303		25. DATE RECD. BY LOCAL REG. JAN 15 '58	
26. REGISTRAR'S SIGNATURE J. Carl Smith MD			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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. D. Richardson*

Licensed Embalmer No. *2978*

P. O. Address *2625 Elm*

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.