

SL-15587 FILED FEB 28 1958
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THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-007113
STATE FILE NUMBER
Registrator's No. 1620

Registration District No. 318 Primary Registration District No. 1003

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE ILLINOIS b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN CHESTER	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION VAH, 915 N. GRAND AVE.		d. STREET ADDRESS 934 WILLIAM STREET	
3. NAME OF DECEASED (Type or print) First Middle Last DAVID S. CROSS		4. DATE OF DEATH Month Day Year 2/10/58	
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 3/3/95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOSPITAL GUARD		10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (City and state or country) ROCKWOOD, ILLINOIS
13a. FATHER'S NAME JULIUS CROSS		13b. MOTHER'S MAIDEN NAME BELLE (NEE) Steele	14. NAME OF HUSBAND OR WIFE BERNICE CROSS
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) YES WW-I		16. SOCIAL SECURITY NO. UNKNOWN	17. INFORMANT Address VAH, 915 NO. GRAND AVE., ST. LOUIS, MO.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE AND CHRONIC PYELONEPHRITIS			INTERVAL BETWEEN ONSET AND DEATH 1 MONTH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) - - - - DUE TO (c) - - - - 600.0H			-
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) RETICULUM CELL SARCOMA LEFT FEMUR - 1 YEAR			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> NONE <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 <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.)	
21. Attended the deceased from 12/23/57 to 2/10/58 and last saw him alive on 2/10/58		21c. Death occurred at 11:11 AM on the date stated above; and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE <i>[Signature]</i>		22b. ADDRESS VAH, ST. LOUIS, MO.	22c. DATE SIGNED 2/10/58
23a. BURIAL CREMATION REMOVAL (Specify) Removal	23b. DATE 2-11-58	23c. NAME OF CEMETERY OR CREMATORY J. T. KAMINSKIS, M. D. Local	23d. LOCATION (City, town, or county) (State) Chester, Illinois
24. FUNERAL DIRECTOR ADDRESS Albert H. Hoppe 4700 Washington, Blvd.		25. DATE RECD. BY LOCAL REG. FEB 11 '58	26. REGISTRAR'S SIGNATURE <i>[Signature]</i>

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

Every disease 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 *Chas R. Sadwell*

Licensed Embalmer No. *4977*
P. O. Address *Sh Lou*

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.