

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-008331  
State File No.

FILED MAR 12 1958

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 317 PRIMARY REG. DIST. NO. 500 Registrar's No. 609

1. PLACE OF DEATH a. COUNTY <u>ST. LOUIS</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>ILLINOIS</u> b. COUNTY <u>ST. CLAIR</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>RURAL - ST. FERDINAND TWP.</u>		c. CITY OR TOWN <u>CAHOKIA</u>	d. In Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. LENGTH OF STAY (In this place) <u>1 MONTH</u>		e. STREET ADDRESS (If rural, give location) <u>1116 RICHARD DR. 8128</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>LULLABY NURSERY 10062 BON OAK DR.</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>STEPHEN</u>	b. (Middle) <u>J.</u>	c. (Last) <u>CROOK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>FEB. 26 1958</u>
-------------------------------------	---------------------------	-----------------------	------------------------	---

5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED (NEVER MARRIED) WIDOWED, DIVORCED (Specify) <u>never married</u>	8. DATE OF BIRTH <u>DEC. 24, 1957</u>	9. AGE (In years last birthday) <u>2</u> if UNDER 1 YEAR Months <u>2</u> Days <u>2</u> if UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
-----------------	----------------------------	---	---------------------------------------	--

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>EAST ST. LOUIS, ILLINOIS</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
---	---	--	---

13a. FATHER'S NAME <u>LYLE CROOK</u>	13b. MOTHER'S MAIDEN NAME <u>BETTY WILSON</u>	14. NAME OF HUSBAND OR WIFE <u>NONE</u>
--------------------------------------	---	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>NONE</u>	17. INFORMANT'S SIGNATURE OR NAME <u>NURSERY RECORDS</u>	ADDRESS
---	--	--	---------

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Hydrocephalus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) <u>752X</u>		
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <u>2</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	----------------------------------	--

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
--	--	---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 1-26, 1958 to 2-25-58, that I last saw the deceased alive on 2-25, 1958 and that death occurred at 3:30 A.M., from the causes and on the date stated above.

23a. SIGNATURE <u>[Signature]</u>	(Degree or title) <u>Dr.</u>	23b. ADDRESS <u>330 St. Francis Florissant</u>	23c. DATE SIGNED <u>2-26-58</u>
-----------------------------------	------------------------------	--	---------------------------------

24a. BURIAL CREMATION REMOVAL <u>REMOVAL</u>	24b. DATE <u>FEB 26, 1958</u>	24c. NAME OF CEMETERY OR CREMATORY <u>ST. JOSEPH'S</u>	24d. LOCATION (City, town, or county) (State) <u>St. Clair County, Illinois</u>
--	-------------------------------	--	---

DATE REC'D BY LOCAL REG. <u>2-27-58</u>	REGISTRAR'S SIGNATURE <u>Herbert R. Donke MD</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>FLORISSANT MORTUARY, FLORISSANT, MO. DASHNER FUNERAL HOME, DUPO, ILL.</u>
---	--	---

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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 *Paul A. Satchers*

Licensed Embalmer No. *4964*

P. O. Address *Flourish*

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.