

Health,  
Welfare  
Public  
Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED APR 3 1958

318

1003

58-011505  
STATE FILE NUMBER

3500  
Registrar's No.

Registration District No. Primary Registration District No.

300  
-57

1

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St. Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>St. Louis</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>4451 Greer Ave</u>		Length of stay in lb <u>36 yrs</u>	d. STREET ADDRESS (If outside, give location) <u>4451 Greer Ave</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANDREW CROSBY</u>			4. DATE OF DEATH Month Day Year <u>March 23 1958</u>
5. SEX <u>Male 2</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 18 1900</u>
9. AGE (In years last birthday) <u>58</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>5</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>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>R.R. Freight House</u>	11. BIRTHPLACE (City and state or country) <u>New Edinburg Ark /</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13a. FATHER'S NAME <u>Nelson Crosby</u>	
13b. MOTHER'S MAIDEN NAME <u>Luzie Owens</u>		14. NAME OF HUSBAND OR WIFE <u>Jessie Crosby</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>702-18-6222</u>	17. INFORMANT Address <u>Mamie Fields 4317 Aldine Ave</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MALNUTRITION - TOXEMIA</u> DUE TO (b) <u>APOPLEXY</u> DUE TO (c) <u>VASCULAR HYPERTENSION - ARTERIOSCLEROSIS.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>334x</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2</u>
20a. ACCIDENT SUICIDE HOMICIDE <input type="checkbox"/> <input type="checkbox"/> <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.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
21. I attended the deceased from <u>3-2-58</u> to <u>3-21-58</u> and last saw <sup>him</sup> alive on <u>3-21-58</u> Death occurred at <u>10:15 A.M.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>Robert E. Long M.D.</u> (Degree or title)		22b. ADDRESS <u>4619 M<sup>th</sup> Millan</u>	22c. DATE SIGNED <u>3-24-58</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE <u>Mar. 28, 1958</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	23d. LOCATION (City, town, or country) (State) <u>St. Louis, Co. MO</u>
24. FUNERAL DIRECTOR ADDRESS <u>J. H. Randle &amp; Son 3133 Bell Ave</u>		25. DATE RECD. BY LOCAL REG. <u>MAR 26 '58</u>	26. REGISTRAR'S SIGNATURE <u>Carl Smith MD</u> <u>m98.</u>

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 *Esther K. Harris* .....

Licensed Embalmer No. *4458* .....  
P. O. Address *4181 Washin* .....

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.