

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-023224
STATE FILE NUMBER

FILED JUN 16 1958 Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 5523

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN University City 5, Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 08 Deaconess Hosp.		Length of stay in lb 3 Days	d. STREET ADDRESS (If outside, give location) 27 6309a Delmar Blvd. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) MR. VICTOR LEWIS CROUCH			4. DATE OF DEATH Month Day Year May 26, 1958
5. SEX M. 0	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> / DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 18, 1902
9. AGE (In years last birthday) 56		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supply Clerk	11. BIRTHPLACE (City and state or country) Seneca Falls N. Y.
12. CITIZEN OF WHAT COUNTRY? USA		13a. FATHER'S NAME William S. Crouch	13b. MOTHER'S MAIDEN NAME Iretta Tunison
14. NAME OF HUSBAND OR WIFE Mildred E. Crouch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW 2	16. SOCIAL SECURITY NO. 490-16-7835
17. INFORMANT Address Mrs. Mildred E. Crouch 6309a Delmar		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <i>Arterio Sclerosis Chronic</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 331x	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		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 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 <i>May 23rd 1958</i> to <i>May 25th 1958</i> and last saw him alive on <i>May 25th 58</i> . Death occurred at <i>4:37 am</i> m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <i>John A. Kowzplian M.D.</i>		(Degree or title) 0	22b. ADDRESS <i>6677 Delmar Rd.</i>
22c. DATE SIGNED <i>5/26/58</i>		23. NAME OF CEMETERY OR CREMATORY <i>Memorial Park Cemetery</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>5/28/1958</i>	23d. LOCATION (City, town, or county) (State) <i>St. Louis County, Missouri</i>
24. FUNERAL DIRECTOR <i>Alexander & Sons</i>		ADDRESS <i>6175 Delmar Blvd.</i>	25. DATE RECD. BY LOCAL REG. <i>MAY 27 58</i>
26. REGISTRAR'S SIGNATURE <i>Carl Smith M.D.</i>			

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

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 *Joe E McCallon*

Licensed Embalmer No. *2964*
P. O. Address *61752 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.