

1. Health,  
& Welfare  
2. Public  
3. Service

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

58-024014  
STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 544 Registrar's No. 1715

FILED JUL 14 1958

S. 300  
v. 1-57

1. PLACE OF DEATH a. COUNTY <b>St. Louis,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri,</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Kirkwood,</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <b>St. Louis,</b> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>St. Joseph Hospital</b>		Length of stay in lb <b>1 DAY 21590</b>	d. STREET ADDRESS (If outside, give location) <b>4229 So. Compton Ave.,</b> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sister M. Martinetta Crahan, C.S.J.</b>			4. DATE OF DEATH Month Day Year <b>June 26, 1958</b>
5. SEX <b>Female.</b>	6. COLOR OR RACE <b>White,</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1917</b>
9. AGE (In years last birthday) <b>40</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Religious,</b>	11. BIRTHPLACE (City and state or country) <b>Kansas,</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13a. FATHER'S NAME <b>Bernard M. Crahan,</b>	
13b. MOTHER'S MAIDEN NAME <b>Mary Foley,</b>		14. NAME OF HUSBAND OR WIFE <b>---None---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT Address <b>Compton Ave.,</b> <b>Sister Thomas Marie C.S.J. 4229 So.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO (b) <b>Rheumatic Heart Disease</b> DUE TO (c) <b>416X</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input 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 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 <b>2/11 158</b> to <b>6/26 158</b> and last saw her <sup>her</sup> alive on <b>6/27/58</b> Death occurred at <b>6:15 A.M.</b> on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) <b>Charles R. Burnett M.D.</b>		22b. ADDRESS <b>20691 Clay, Kirkwood</b>	22c. DATE SIGNED <b>6/27/58</b>
23a. BURIAL, CREMATION, REMOVAL (specify) <b>Removal.</b>	23b. DATE <b>6/30/58</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery,</b>	23d. LOCATION (City, town, or county) (State) <b>St. Louis, Missouri,</b>
24. FUNERAL DIRECTOR <b>Gebken-Benz Mortuary,</b>		ADDRESS <b>2842 Meramec St.,</b> <b>St. Louis, 18, Mo.</b>	25. DATE REG. BY LOCAL REG. <b>6/27/58</b>
26. REGISTRAR'S SIGNATURE <b>Herbert R. Donke</b>		27. <b>TR</b>	

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

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed

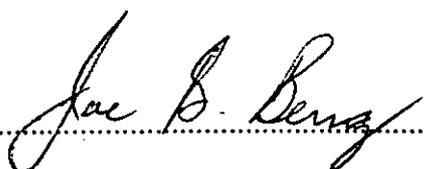
by me, or by ME, Student Embalmer No. ....

working under my personal supervision.

Student .....

Signature of Student Embalmer

Signed .....



Licensed Embalmer No. 4249  
2842 Meramec St  
P. O. Address.....St. Louis, 18,

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.