

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-031252

STATE FILE NUMBER

FILED AUG 22 1958 Registration District No. 317 Primary Registration District No. 544 Registrar's No. 2130

1. PLACE OF DEATH a. COUNTY St. Louis		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY JEFFERSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kirkwood		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN Imperial 0500 0
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Joseph		Length of stay in lb 20 hours	d. STREET ADDRESS (If outside, give location) Route 1 Box 234
3. NAME OF DECEASED (Type or print) First Barbara Middle Ann Last Crowe			4. DATE OF DEATH Month 8 Day 14 Year 1958
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-8-1951
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 6 IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 0 Min. 0
11. BIRTHPLACE (City and state or country) St. Louis		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME John		13b. MOTHER'S MAIDEN NAME Theresa Czarnecki	14. NAME OF HUSBAND OR WIFE NONE
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT John Crowe Address same
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage Fracture Skull Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) 900.0 DUE TO (c) 21			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT <input checked="" 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.) Fell down stairs	
20c. TIME OF INJURY Hour 8-13-58 a.m. 8-13-58 p.m.		20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home	
20e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20f. CITY, TOWN, OR LOCATION Imperial COUNTY Jefferson STATE Mo.	
21. I attended the deceased from 8-13-58 to 8-14-58 and last saw her alive on 8-14-58 Death occurred at 5:30 pm m on the date stated above; and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE Carl L. Erick (Degree or title)		22b. ADDRESS 1101 Webster Groves	
22c. DATE SIGNED 8-15-58		22d. DATE SIGNED	
23a. PLACE OF CREMATION (If cremated) Burial	23b. DATE 8-18-1958	23c. NAME OF CEMETERY OR CREMATORY Calvary	23d. LOCATION (City, town, or county) (State) St. Louis Mo.
24. FUNERAL DIRECTOR ST. LOUIS FUNERAL HOME 2205 St. Louis Ave.		25. DATE RECD. BY LOCAL REG. 8-15-58	26. REGISTRAR'S SIGNATURE Herbert G. Dombke M.D.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

2016 113

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 *John S. Denne*
Licensed Embalmer No. *4194*
P. O. Address *St. Louis*

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.