

Health, Welfare, Public Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-046689

STATE FILE NUMBER

JAN 6 1959 Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3388

300
-57

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>St. Louis</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR <u>Richmond Heights</u> TOWN		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>4356 University City</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>St. Mary's Hosp.</u>		Length of stay in lb <u>2 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>122C Waldron Ave.</u> Reside on Form Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Hannah</u> Middle <u>A.</u> Last <u>Crilly</u>			4. DATE OF DEATH Month <u>12</u> Day <u>25</u> Year <u>58</u>			
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> 2 DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-1-1886</u>	9. AGE (in years last birthday) <u>72</u>	10. FUNDER 1 YEAR Months <u>33</u> Days <u>18</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (City and state or country) <u>St. Louis, Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
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13a. FATHER'S NAME <u>Frank Edwards</u>	13b. MOTHER'S MAIDEN NAME <u>Hannah</u>	14. NAME OF HUSBAND OR WIFE <u>Deceased</u>
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or, or unknown) (If yes, give war or dates of service) <u>None</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT <u>Martha Schergens</u>	Address <u>122C Waldon Ave.</u>
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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>C.V.A.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>?</u> <u>?</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) <u>Hypertension</u>	
	DUE TO (c) <u>Atherosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes</u>		19. WAS AUTOPSY PERFORMED? Refer <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> <u>None</u>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>None</u>
20c. TIME OF INJURY Hour <u>None</u> Month <u>None</u> Day <u>None</u> Year <u>None</u>	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <u>None</u>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, etc.) <u>None</u>	20f. CITY, TOWN, OR LOCATION <u>None</u>	COUNTY <u>None</u>	STATE <u>None</u>
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21. I attended the deceased from Death occurred at <u>12-23-58</u> to <u>12-25-58</u> and last saw her alive on <u>12-24-58</u> <u>3:00a</u> m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <u>Robert E. Jacobs, D.O.</u>	22b. ADDRESS <u>416 Linden Blvd</u>	22c. DATE SIGNED <u>12-26-58</u>
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23a. DATE <u>12-27-58</u>	23b. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>	23c. LOCATION (City, town, or county) (State) <u>St. Louis Missouri</u>
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24. FUNERAL DIRECTOR <u>Jos. W. Clark F.H.</u>	ADDRESS <u>1125 Hodiament Ave.</u>	25. DATE RECD. BY LOCAL REG. <u>12-26-58</u>	26. REGISTRAR'S SIGNATURE <u>Herbert R. Dooly, M.D.</u>
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(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1 to 6 P.M.

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 *Alfred J. Borden*

Licensed Embalmer No. *2166*

P. O. Address *1125 Hyde*

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.