Health, Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002815
STATE FILE NUMBER

FILED FEB 4 1959 Registration District No. ..... Primary Registration District No. ..... Registrar's No. 2 739

1. PLACE OF DEATH
a. COUNTY St. Louis City
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA City Hosp I — Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission.)
a. STATE Missouri b. COUNTY St. Louis City
c. CITY OR TOWN St. Louis — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS 4367 Maryland Apt - 16 — Reside on Farm Yes ☐ No ☑

3. NAME OF DECEASED (Type or print) First Larry Middle Wayne Last Crew
4. DATE OF DEATH Month 1 Day 22 Year 1959
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Sept. 27, 1958
9. AGE (In years last birthday) — IF UNDER 1 YEAR Months 3 Days 25 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (City and state or country) St. Louis, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13a. FATHER'S NAME Harold Crew
13b. MOTHER'S MAIDEN NAME Martha Gandy
14. NAME OF HUSBAND OR WIFE Infant
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mr. Parks Gandy — Address St. Louis, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Broncho Pneumonia
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)
DUE TO (c) 491X
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 ☑ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
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 ..... to ..... and last saw her/him alive on .....
Death occurred at 7:15 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE [signature] Degree M.D. — 22b. ADDRESS 1300 Clark — 22c. DATE SIGNED 1/22/59

23a. BURIAL, CREMATION, REMOVAL (Specify) Removal — 23b. DATE 1-22-1959 — 23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery — 23d. LOCATION (City, town, or county) (State) Cuba Mo.

24. FUNERAL DIRECTOR [signature] — ADDRESS Cuba, Mo.
25. DATE REC'D BY LOCAL REG. JAN 22 '59
26. REGISTRAR'S SIGNATURE [signature] MD

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 3472

P. O. Address Ulka, Mo.

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.