

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-014848
STATE FILE NUMBER
2 4055
Registrar's No.

Registration District No. _____ Primary Registration District No. _____

FILED MAY 11 1959

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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

1. PLACE OF DEATH a. COUNTY <u>St Louis</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ILLINOIS</u> b. COUNTY <u>Jackson</u>		
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>St Louis</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <u>Dowell</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. John Hosp</u>		Length of stay in lb <u>27 DAYS</u>	d. STREET ADDRESS (If outside, give location) <u>NONE</u>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>W</u> Last <u>Crow</u>			4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>59</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 9 1891</u>		9. AGE (In years last birthday) <u>68</u>
10a. USUAL OCCUPATION (Give kind of work done during postwar working life, even if retired) <u>MINER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mine</u>	11. BIRTHPLACE (City and state or country) <u>Vergerennes ILL</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>NOT KNOWN</u>		13b. MOTHER'S MAIDEN NAME <u>NOT KNOWN</u>		14. NAME OF HUSBAND OR WIFE <u>Sarah Crow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>343-05-5207</u>	17. INFORMANT <u>Sarah Crow Dowell Ill</u> Address		
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>Enteroperitoneal wound infection with</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. } DUE TO (b) <u>septic sinus + pyelonephritis</u> DUE TO (c) <u>Carcinoma of bladder</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>St Croix County Illinois 1810</u>					INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>
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 _____ a.m. _____ p.m.			20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20f. CITY, TOWN, OR LOCATION		COUNTY	STATE
21. I attended the deceased from <u>3-6-59</u> to <u>4-23-59</u> and last saw ^{from} him alive on <u>4-23-59</u> Death occurred at <u>8:00 P. m.</u> on the date stated above; and to the best of my knowledge, from the causes stated.					
22a. SIGNATURE <u>Dr. T. DeFury M.D.</u> (Degree or title)			22b. ADDRESS <u>634 N. Grand</u>		22c. DATE SIGNED <u>4-24-59</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>4/25/59</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PARRISH Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Vergerennes Township ILL</u>
24. FUNERAL DIRECTOR <u>Schroeder</u>		ADDRESS <u>Dr Quoin, ILL</u>		25. DATE RECD. BY LOCAL REG. <u>APR 25 59</u>	26. REGISTRAR'S SIGNATURE <u>Loal Smith M.D.</u>

(H.T.)

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 *Kenneth Proloff*

Licensed Embalmer No. *4386*

P. O. Address *St. Louis, 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.