

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

59-019072

State File No. ....

No. 300  
10-48

FILED JUN 4 1959

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. \_\_\_\_\_ PRIMARY REG. DIST. NO. \_\_\_\_\_ Registrar's No. **2 5015**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>ILLINOIS</b> b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give town) <b>ST LOUIS</b>	c. LENGTH OF STAY (in this place) <b>5 WEEKS</b>	c. CITY OR TOWN <b>ALMA</b>	d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>MISSOURI BAPTIST</b>		e. STREET ADDRESS (If rural, give location)	

3. NAME OF DECEASED (Type or Print) a. (First) <b>DAYTON</b>	b. (Middle)	c. (Last) <b>CRUTCHFIELD</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>MAY 23 1959</b>
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5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>7-22-1896</b>	9. AGE (In years last birthday) <b>62</b>	10. IF UNDER 1 YEAR Months <b>10</b> Days	11. IF UNDER 1 MRS. Hours Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>KINMUNDY ILL</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13a. FATHER'S NAME <b>ARTHUR J. CRUTCHFIELD</b>	13b. MOTHER'S MAIDEN NAME <b>COLE MILLER</b>	14. NAME OF HUSBAND OR WIFE <b>SADIE Susie</b>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. <b>326-26-5337</b>	17. INFORMANT'S SIGNATURE OR NAME <b>MRS. SADIE CRUTCHFIELD</b>	ADDRESS
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>brain tumor - astrocytoma</b> <b>Brain tumor (ASTROCYTOMA)</b>	INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) <b>none</b> DUE TO (c) <b>193.0</b>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>DIFFUSE ASTROCYTOMA (LEFT OCCIPITAL LOBE)</b>	20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR BY AFFIDAVIT OF Informant <b>6-25-59</b>
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22. I hereby certify that I attended the deceased from **4-26**, 19**59**, to **5-23**, 19**59**, that I last saw the deceased alive on \_\_\_\_\_, 19\_\_\_\_, and that death occurred at **4:40** a. m., from the causes and on the date stated above.

23a. SIGNATURE <b>Jacques P. Schaefer</b> <i>Jacques P. Schaefer, M.D.</i>	(Degree or title)	23b. ADDRESS <b>6944 Chippewa St. Louis, Mo</b>	23c. DATE SIGNED <b>5-23-59</b>
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24a. BURIAL (CREMATION, REMOVAL) (Specify) <b>BURIAL</b>	24b. DATE <b>MAY 25-1959</b>	24c. NAME OF CEMETERY OR CREMATORY <b>PHILIPPS</b>	24d. LOCATION (City, town, or county) (State) <b>MARION Co., ILL.</b>
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DATE REC'D BY LOCAL REG. <b>MAY 23 59</b>	REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>	25. FUNERAL DIRECTOR'S SIGNATURE <b>W. K. ...</b>	ADDRESS <b>EAST ST LOUIS, ILL.</b>
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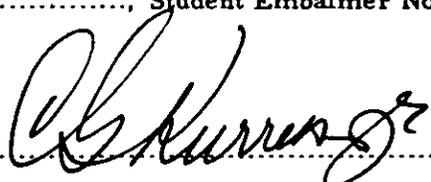
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

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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. 3160

P. O. Address.....

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.