

UNITED STATES DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS NOV 4 1959

59-037126

STATE FILE NUMBER

Registration District No. 275 Primary Registration District No. 3053 Registrar's No. 202

1. PLACE OF DEATH a. COUNTY Phelps				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Illinois b. COUNTY St. Clair			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Rolla		Length of stay in Institution Enroute to Hospital		c. CITY OR TOWN E. St. Louis		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION DOA Phelps Co. Hosp.				Institution Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 1419 Nectar Ave.	
3. NAME OF DECEASED (Type or print) First DONALD Middle BRUCE Last CRISSUP				4. DATE OF DEATH Month Oct. Day 29 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		8. DATE OF BIRTH 1/27/1935	
9. AGE (last birthday) 24		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY University		11. BIRTHPLACE (City and state or country) E. St. Louis, Ill.	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME George Edw. Crissup		13b. MOTHER'S MAIDEN NAME Stella Juracek		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) Yes 3/57 to 3/59				16. SOCIAL SECURITY NO.		17. INFORMANT Address G. E. Crissup E. St. Louis Ill.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Massive, Thrombotic Hemorrhage						1 hour	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Crushed chest.							
DUE TO (c) Automobile Accident							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT SUICIDE HOMICIDE <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) Automobile which deceased was driving			
20c. TIME OF INJURY. Hour 7 p.m. Month, Day, Year 10/29/59		went out of control on curve, turned over, throwing driver from car.					
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway		20f. CITY, TOWN, OR LOCATION Hwy 32-72 7 mi E. of Salem		COUNTY Dent STATE Mo.	
21. I attended the deceased from _____, to _____ and last saw her him alive on _____ Death occurred at Approx. 8:00 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE (Degree or title) D. L. Stoll, Registrar, Phelps Co., Rolla, Mo.				22b. ADDRESS		22c. DATE SIGNED 10/30/59	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 10/30/59		23c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		23d. LOCATION (City, town, or county) (State) Belleville, Illinois	
24. FUNERAL DIRECTOR Sedlack				25. DATE RECD. BY LOCAL REG. Oct. 30, 1959		26. REGISTRAR'S SIGNATURE Nadine L. Stoll	

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

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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 m

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Max L. Waugh

Licensed Embalmer No.

4170

P. O. Address

Salem, N.C.

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.