

FRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

60-012477

FILED VS APR 4 1960

Registration District No. _____ Primary Registration District No. _____ Registrar No. **2 2787** STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MISSOURI b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS, MISSOURI		c. CITY OR TOWN FENTON, 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 BARNES HOSPITAL		d. STREET ADDRESS (If outside, give location) Box 362, Rt. 2. Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last NORMAN T. CRONAN			4. DATE OF DEATH Month Day Year MARCH 9 1960			
---	--	--	---	--	--	--

5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 10/29/1929	9. AGE (last birthday) 30 years	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HR
-----------------------	----------------------------------	---	---------------------------------------	---	---	----------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER	10b. KIND OF BUSINESS OR INDUSTRY LINDBERG SCHOOL	11. BIRTHPLACE (City and state or country) ST. LOUIS, MO.	12. CITIZEN OF WHAT COUNTRY U.S.A.
--	---	---	--

13a. FATHER'S NAME G. Leslie Cronan	13b. MOTHER'S MAIDEN NAME Etta Mae Cronan	14. NAME OF HUSBAND OR WIFE Doris Cronan
---	---	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes Korean War	16. SOCIAL SECURITY NO. 499-30-7631	17. INFORMANT Address Edward Petrikovitsch, 3243 Indiana Ave.
---	---	---

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) INTRA-CEREBRAL HEMORRHAGE		2 DAYS
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.	DUE TO (b) RUPTURED ARTERIOVENOUS MALFORMATION	30 YEARS
	DUE TO (c) 7547	
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 checked="" type="checkbox"/> NO <input type="checkbox"/>	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.	Month, Day, Year
---------------------------------------	------------------

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	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 **MARCH 4, 1960** to **MARCH 9, 1960** and last saw her/him alive on **MARCH 9, 1960**
Death occurred at **8:05 A.M.** on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <i>C. Demillion, M.D.</i>	(Degree or title) M. D.	22b. ADDRESS BARNES HOSPITAL	22c. DATE SIGNED 3/9/60
---	-----------------------------------	--	-----------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE MARCH 11, 1960	23c. NAME OF CEMETERY OR CREMATORY NATIONAL CEMETERY	23d. LOCATION (City, town, or county) (State) ST. LOUIS CO. MISSOURI
---	------------------------------------	--	--

24. FUNERAL DIRECTOR ADDRESS Witt Bros. L. & U. Co. 2929 S. Jefferson Ave.	25. DATE RECD. BY LOCAL REG. MAR 10 1960	26. REGISTRAR'S SIGNATURE <i>Leon Smith, M.D.</i>
--	--	--

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

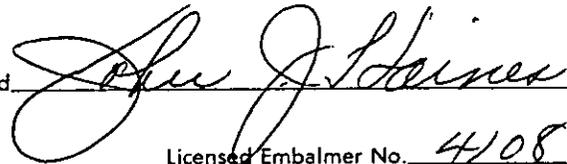


STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by _____, Student Embalmer No. _____, or by _____, Student Embalmer No. _____, working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed


Licensed Embalmer No. 4108

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to do so 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.