

**JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**

**60-020804**

**FILED VS JUN 9 1960 318**

**1003**

**4965**

STATE FILE NUMBER

Registration District No. \_\_\_\_\_ Primary Registration District No. \_\_\_\_\_ Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Missouri</i> b. COUNTY									
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>St Louis</i>		Length of stay in 1b <i>4 mo.</i>		c. CITY OR TOWN <i>St Louis</i>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>City Hospital #1</i>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (if outside, give location) <i>2809 HENRIETTA</i>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <i>EARL</i> Middle <i>W.</i> Last <i>CRIM</i>				4. DATE OF DEATH Month <i>MAY</i> Day <i>18</i> Year <i>1960</i>									
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>White</i>		7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>9-22-1894</i>		9. AGE (last birthday) <i>65</i>		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HR Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Tailor Retired</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Clothing</i>		11. BIRTHPLACE (City and state or country) <i>Franklin Co. Ill.</i>		12. CITIZEN OF WHAT COUNTRY <i>U. S. A</i>					
13a. FATHER'S NAME <i>ALVA CRIM</i>				13b. MOTHER'S MAIDEN NAME <i>MARY MUIR</i>				14. NAME OF HUSBAND OR WIFE <i>LORAINÉ</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO. <i>337-09-1712</i>		17. INFORMANT <i>MRS O.W. ETTERS, JR.</i>		Address <i>Freeburg, Illinois</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Fracture of Left Hip</i> DUE TO (b) <i>Arterio Sclerosis</i> DUE TO (c) <i>9000 21</i> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH			
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 <input checked="" 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.) <i>Suffered in fall down</i>									
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year <i>1. 7. 60 steps of Staircase January 7, 1960</i>		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.) <i>Home</i>		20f. CITY, TOWN, OR LOCATION <i>St Louis Mo</i>		COUNTY		STATE		
21. I attended the deceased from _____ to _____ and last saw him alive on _____ Death occurred at <i>1240 P</i> m on the date stated above, and to the best of my knowledge, from the causes stated.													
22a. SIGNATURE (Degree or title) <i>Patrick C. Taylor Carmel</i>				22b. ADDRESS <i>1300 Clark</i>				22c. DATE SIGNED <i>5.11.60</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		23b. DATE <i>5-11-60</i>		23c. NAME OF CEMETERY OR CREMATORY <i>I.O.O.F. Cem</i>				23d. LOCATION (City, town, or county) (State) <i>West Frankfort Illinois</i>					
24. FUNERAL DIRECTOR <i>Stone</i>				ADDRESS <i>West Frankfort Ill</i>		25. DATE RECD. BY LOCAL REG. <i>MAY 11 1960</i>		26. REGISTRAR'S SIGNATURE <i>Loan Smith, M.D.</i> <i>mrb</i>					

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

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

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed: Frank Proff

Licensed Embalmer No. 4356

P. O. Address St Louis, Mo

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