

U.S. DEPARTMENT OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-033370

FILED IN SEP 1 2 1960
INDEXED

Registration District No. 317 Primary Registration District No. 500 Registrar's No. 2452 STATE FILE NUMBER

1. PLACE OF DEATH a. COUNTY <u>St. Louis</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>St. Louis</u>			
b. CITY (If outside corporate limits, give TOWNSHIP only) <u>Koch</u>		Length of stay in 1b <u>6 days</u>		c. CITY OR TOWN <u>St. Louis</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>Robert Koch Hospital</u>				Inside Units Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>5144 Enright</u>	
3. NAME OF DECEASED (Type or print) First <u>BURNS</u> Middle <u>CRAWFORD</u> Last <u>CRAWFORD</u>				4. DATE OF DEATH Month <u>8</u> Day <u>15</u> Year <u>60</u>			
5. SEX <u>M</u>	6. COLOR OF RACE <u>N</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>4-10-20</u>	9. AGE (last birthday) <u>40</u>	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) <u>COOK</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (City and state or country) <u>MISSOURI</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>
13a. FATHER'S NAME <u>ROBERT CRAWFORD</u>			13b. MOTHER'S MAIDEN NAME <u>LUCILLE JOHNSON</u>		14. NAME OF HUSBAND OR WIFE <u>MARIE CRAWFORD</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>			16. SOCIAL SECURITY NO. <u>unk.</u>		17. INFORMANT <u>Koch Hospital Chart</u>		
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>Cardiovascular collapse</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Extensive mesothelial tumor</u>						Unknown	
DUE TO (c) <u>throughout abdomen</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Retroperitoneal leiomyosarcoma</u>						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 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 Month, Day, Year a.m. p.m.							
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 <u>8-9-60</u> to <u>8-15-60</u> and last saw her alive on <u>8-15-60</u> Death occurred at <u>9:35 AM</u> on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>Harold G. Sewell, M.D.</u> (Degree or title)				22b. ADDRESS <u>Koch Hosp</u>			22c. DATE SIGNED <u>8/15/60</u>
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (Specify)			
<u>Burial</u>	<u>8/18/60</u>	<u>Father Dickson</u>		<u>St. Louis, Co. Mo</u>			
24. FUNERAL DIRECTOR		ADDRESS		25. DATE RECD. BY LOCAL REG.		26. REGISTRAR'S SIGNATURE	
<u>L. B. Home</u>		<u>1221 N. Grand</u>		<u>8-17-60</u>		<u>Jan. C. Murphy, M.D.</u>	

BY AFFIDAVIT OF Signed Statement Med. Dir. 10-1-60
MEDICAL CERTIFICATION

SEP 13 1980

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 Melvin Blackman

Licensed Embalmer No. 3962

P. O. Address 1291 N. ...

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.