

JURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

80-036885
STATE FILE NUMBER

FILED VS. OCT 10 1960

317

Primary Registration District No. 543

Registrar's No. 2888

ENDED

DOCUMENT

1. PLACE OF DEATH a. COUNTY St. Louis				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 Jennings		Length of stay in 1b 9 yr		c. CITY OR TOWN Jennings		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>									
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 2428 Weick Dr			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) 2428 Weick Dr		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First BERNIECE Middle M Last CROCKER				4. DATE OF DEATH Month October Day 3rd , Year 1960											
5. SEX female		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 1/18/27		9. AGE (last birthday) 33		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) blinder			10b. KIND OF BUSINESS OR INDUSTRY printing			11. BIRTHPLACE (City and state or country) St. Louis, Mo			12. CITIZEN OF WHAT COUNTRY USA						
13a. FATHER'S NAME Dominac Farace				13b. MOTHER'S MAIDEN NAME Mary Spicuzzi				14. NAME OF HUSBAND OR WIFE Ernest W. Crocker							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			16. SOCIAL SECURITY NO. 499-26-5477			17. INFORMANT Address Ernest Crocker, 2428 Weick Dr.,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis										INTERVAL BETWEEN ONSET AND DEATH 3 mos.					
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.										DUE TO (b) adenocarcinoma of sigmoid + Lt Ovary.		DUE TO (c)		9 mos	
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 checked="" 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 _____ s.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 Feb 1960 to present and last saw her alive on 10/1/62 Death occurred at 2:00 AM P.m on the date stated above, and to the best of my knowledge, from the causes stated.															
22a. SIGNATURE M.A. Cassel, M.D. (Degree or title)						22b. ADDRESS 3400 N. Kingshighway				22c. DATE SIGNED 10					
23a. BURIAL, CREMATION, REMOVAL (Specify) removal			23b. DATE 10/5/60		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery			23d. LOCATION (City, town, or county) St. Louis, Mo. (State)							
24. FUNERAL DIRECTOR Emil J. Heotzenroeder, 8319 Hallsferry ADDRESS					25. DATE RECD. BY LOCAL REG. 10-3-60		26. REGISTRAR'S SIGNATURE John M. Murphy M.D.								

BY AFFIDAVIT OF

Signature

Initials

Signature

Sex

Age

Color

Equipped

Married

X

Married

Place of Birth

Place of Birth

Place of Birth

SS

TS

X

State

County

Religion

Religion

Religion

Place of Death

Place of Death

Place of Death

Place of Burial

Place of Burial

On

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 Harry E. Monroe

Licensed Embalmer No. 4495

P. O. Address St. Louis,

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.