

FEDERAL DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

FILED VS OCT 10 1960

=60-036914

INDEXED

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 2919 STATE FILE NUMBER

| | | | | | | | |
|---|---|---|--|--|--|--|---|
| 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 RICHMOND HEIGHTS | | Length of stay in 1b 1 day | | c. CITY OR TOWN ARBOR TERRACE | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST MARY'S HOSPITAL | | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) 3717 MELBA PLACE | | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First LEO Middle G. Last CRADEN SR. | | | | 4. DATE OF DEATH Month OCT, Day 3, Year 1960 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/> | | 8. DATE OF BIRTH FEB. 16 1888 | 9. AGE (last birthday) 72 | 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) RETIRED CLERK | | | 10b. KIND OF BUSINESS OR INDUSTRY _____ | | 11. BIRTHPLACE (City and state or country) ST LOUIS MISSOURI | | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
| 13a. FATHER'S NAME JOSEPH CRADEN | | | 13b. MOTHER'S MAIDEN NAME ELIZABETH DAVIS | | | 14. NAME OF HUSBAND OR WIFE _____ | |
| 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. 497-07-7219 | | 17. INFORMANT LEO G. CRADEN JR. 3717 MELBA PLACE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hr DUE TO (b) Coronary thrombosis 3 hr 10 min Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (c) _____ | | | | | | | |
| 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 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 10/3/60 to 10/3/60 and last saw her/him alive on 10/3/60 Death occurred at 1:15 P m on the date stated above, and to the best of my knowledge, from the causes stated. | | | | | | | |
| 22a. SIGNATURE (Degree or title) Murray Chinsky, M.D. | | | | 22b. ADDRESS 6223 Natural Bridge | | 22c. DATE SIGNED 10/14/60 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL | | 23b. DATE 10/6/60 | 23c. NAME OF CEMETERY OR CREMATORY CALVARY CEMETERY | | 23d. LOCATION (City, town, or county) ST LOUIS MISSOURI | | (State) |
| 24. FUNERAL DIRECTOR STROOT - CARROLL 4600 NATURAL BRIDGE | | | | 25. DATE RECD. BY LOCAL REG. 10-5-60 | | 26. REGISTRAR'S SIGNATURE John E. Murphy M.D. | |

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

*Dr. Chensel
6223 North Brent
St. Louis Mo 63113
430 per*

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 *M W Rueter*

Licensed Embalmer No. *4865*

P. O. Address *St Louis Mo*

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.