

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-030656

STATE FILE NUMBER

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED AUG 28 1961 818

1003

7763

DATE AMENDED

INSTEAD OF THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MO</u>		Length of stay in 1b <u>8WK-1day</u>		c. CITY OR TOWN <u>MAPLEWOOD</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>DEACONESS HOSPITAL</u>				Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <u>3603 COMMONWEALTH</u>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE B CROUCH</u>				4. DATE OF DEATH Month Day Year <u>8-20-1961</u>				
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</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>5-21-1900</u>		
9. AGE (last birthday) <u>61</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>HOUSEWIFE</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (City and state or country) <u>STOCKTON, MO</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WALTER J. LOZAR</u>			13b. MOTHER'S MAIDEN NAME <u>MELVIANA WILSON</u>			14. NAME OF HUSBAND OR WIFE <u>WILLIAM CROUCH</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>W.M. CROUCH</u>		Address <u>3603 COMMONWEALTH</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>malignant melanoma of right leg with metastases to entire body.</u>							INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____							<u>1907</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Diabetes mellitus</u>						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 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 <u>1-16-60</u> to <u>8-20-61</u> and last saw her/him alive on <u>8-20-61</u> . Death occurred at <u>4-35p.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE (Degree or title) <u>Ernest H. Schaper, M.D.</u>				22b. ADDRESS <u>7200 manchester</u>		22c. DATE SIGNED <u>8-21-61</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		23b. DATE <u>8-24-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EAST LAWN CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>SPRINGFIELD MO</u>		
24. FUNERAL DIRECTOR <u>HOWARD H. MICHEL</u>				ADDRESS <u>5930 SOUTHWEST</u>		25. DATE RECD. BY LOCAL REG. <u>AUG 21 1961</u>		
26. REGISTRAR'S SIGNATURE <u>Loed Smith, M.D.</u>								

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 me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

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

Signed Herbert J. Gass Jr.

Licensed Embalmer No. 4800

P. O. Address Kirkwood 22, 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.