ISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

-61-043110

RTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

Registration District No. 317 Primary Registration District No. 547 Registrar's No. 3332

FILED NOV 30 1961

AMENDED

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY St. Louis
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Richmond Hts. — Length of stay in 1b 6 Days
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Mary's Hospital — Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY St. Louis
c. CITY OR TOWN Affton — Inside Limits Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) 7140 Rhodes Ave. — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First CARL Middle B. Last CRACKEL

4. DATE OF DEATH Month Nov. Day 23 Year 1961

5. SEX Male

6. COLOR OR RACE White

7. Married ☒ Never Married ☐ Widowed ☐ Divorced ☐

8. DATE OF BIRTH 1-4-1893

9. AGE (last birthday) 68 — 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) Stationary Engineer-Photo

10b. KIND OF BUSINESS OR INDUSTRY Paper Products

11. BIRTHPLACE (City and state or country) Browns, Ill.

12. CITIZEN OF WHAT COUNTRY U.S.A.

13a. FATHER'S NAME Lyman Cracker

13b. MOTHER'S MAIDEN NAME Alice Felstead

14. NAME OF HUSBAND OR WIFE Mary M. Crackel

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

17. INFORMANT Mary M. Crackel Address 7140 Rhodes Ave.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion acute — INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) gen arteriosclerosis
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Diabetes mellitus
PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

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 ☐ NOT WHILE AT WORK ☐

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 1960, to 11/23/61 and last saw her/him alive on 11/23/61
Death occurred at 2:15 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) Vallan J Dyer M.D.

22b. ADDRESS 3915 Watson Rd

22c. DATE SIGNED 11/24/61 (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial

23b. DATE Nov. 27, 1961

23c. NAME OF CEMETERY OR CREMATORY Lakewood Park Cemetery

23d. LOCATION (City, town, or county) St. Louis Co. Mo.

24. FUNERAL DIRECTOR ADDRESS Kriegshauser 4228 S. Kingshighway Blvd.

25. DATE RECD. BY LOCAL REG. 11-24-61

26. REGISTRAR'S SIGNATURE John C. Murphy M.D.

(Licensed Embalmer's Statement on Reverse Side)

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 _____

Licensed Embalmer No. 4533

P. O. Address _____

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.