

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-62-023690

STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 160 Primary Registration District No. 559v Registrar's No. 94

FILED JUN 26 1962

VS 300
Rev. 4/59

10500

20500

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94344

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1290-2

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Jefferson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri COUNTY Jefferson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Joachim Twp.		Length of stay in 1b 43 years	c. CITY OR TOWN Festus
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Buck Knob Road		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	d. STREET ADDRESS (If outside, give location) Rte. # 1
3. NAME OF DECEASED (Type or print) First CLARENCE Middle EDWIN Last CROSBY		4. DATE OF DEATH Month June Day 17 Year 1962	
5. SEX Male	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 2-10-94
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) Doctor of Osteopathy		10b. KIND OF BUSINESS OR INDUSTRY General Practice	11. BIRTHPLACE (City and state or country) O'Fallon, Illinois
12. CITIZEN OF WHAT COUNTRY U.S.A.		13a. FATHER'S NAME William R. Crosby	
13b. MOTHER'S MAIDEN NAME Lillie Corbridge		14. NAME OF HUSBAND OR WIFE Anna M. Bechtold	
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.	
17. INFORMANT Mrs. Anna M. Crosby, Rte. # 1, Festus, Mo.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation			INTERVAL BETWEEN ONSET AND DEATH Months
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Coronary insufficiency DUE TO (c) left ventricular hypertrophy			one year
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 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 November 1961 to June 17, 1962 and last saw ^{her} him alive on 6/15/62 Death occurred at 4:45 Pm S.T. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) W.A. Rabbington D.D.		22b. ADDRESS Plot Power Mo	
22c. DATE SIGNED 6/18/62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE 6-19-62	
23c. NAME OF CEMETERY OR CREMATORY City Cemetery		23d. LOCATION (City, town, or county) (State) O'Fallon, Illinois	
24. FUNERAL DIRECTOR Vinyard Funeral Home, Inc., Festus, Mo.		25. DATE RECD. BY LOCAL REG. 6/19/62	
26. REGISTRAR'S SIGNATURE Ch. G. [Signature]		27. REGISTRAR'S TITLE Stall Deputy	

[Handwritten signature]

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 *Keith B. Simpson*

Licensed Embalmer No. 4976

P.O. Address Festus, 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.