

1939 FEB 21 1939

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

2549
Do not use this space.

1. PLACE OF DEATH

(a) County Jackson Registration District No. 398
(b) Township Independence Primary Registration District No. 3019 Registered No. 16
(c) City Independence (d) Street No. 505 East Aberdeen St. Mo.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. 505 East Aberdeen St. Mo. (If nonresident, give city or town and State)
(Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Widowed
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) June 26-1862
7. AGE YEARS 76 MONTHS 6 DAYS 22 If LESS than 1 day, hrs. or min.
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. House work
9. Industry or business in which work was done, as saw mill, bank, etc. at Home
10. Date deceased last worked at this occupation (month and year) 11. Total time (years) spent in this occupation 59

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Jan 18 1939
22. I HEREBY CERTIFY That I attended deceased from Oct 6 1938 to Jan 18 1939
I last saw her alive on Jan 18 1939. Death is said to have occurred on the date stated above, at 10:20 a.m.
The principal cause of death and related causes of importance were as follows:

Cardio-vascular renal disease, with cardiac decompensation
Other contributory causes of importance: Diabetes & Past 2 or 3 years Hypertension

Name of operation none Date of
What test confirmed diagnosis? Chemical Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? Date of injury 19.....
Where did injury occur? (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no
If so, specify
(Signed) R. Haller M. D.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

New Trenton, Indiana

FATHER

13. NAME Fred C. Crote
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS)

Raymond W. Crotts
115 South Leslie

18. BURIAL, CREMATION, OR REMOVAL

PLACE Mount Grove DATE Jan 20 1939

19. FUNERAL DIRECTOR (ADDRESS)

Funeral Home
Independence Mo.

20. FILED

1-24-39 F. L. Cook
Local Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I,, Licensed Embalmer No.....

hereby certify that the body recorded on the reverse side of this certificate was embalmed by.....

..... L. E.

No.....or by....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

Licensed Embalmer No.....

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.)