

NOV 24 1939

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

35862  
Do not use this space.

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.

26  
3  
5

1. PLACE OF DEATH

(a) County Coll. 1 Registration District No. 213  
 (b) Township Jefferson. 1 Primary Registration District No. 3014 Registered No. 235  
 (c) City Jefferson. (d) Street No. St. Andrew Hospital St.  
 (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

650 Barbara Ann Crane.  
 (a) Residence, No. 213 E. Cedar. St.  (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) Child.  
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Child.  
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Sept. 18, 1938.  
 7. AGE YEARS MONTHS DAYS IF LESS than 1 day, hrs. or min.  
1 0 19  
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Child.  
 9. Industry or business in which work was done, as saw mill, bank, etc.  
 10. Date deceased last worked at this occupation (month and year)  
 11. Total time (years) spent in this occupation  
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Jefferson city, Missouri - 0  
 FATHER 13. NAME Ogal Crane. 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Thoscomb, Missouri  
 MOTHER 15. MAIDEN NAME Geneva Chaplain 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Meta, Missouri  
 17. INFORMANT (ADDRESS) Ogal Crane, Jefferson city, Mo.  
 18. BURIAL, CREMATION, OR REMOVAL PLACE Meta Mo. DATE 10/9, 1939  
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Funeral Service, Jefferson city, Mo.  
 20. FILED 10/10/1939 D. W. Beal Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct. 7th, 1939.  
 22. I HEREBY CERTIFY, That I attended deceased from Feb 10, 1938, to Oct 7, 1939  
 I last saw her alive on 5 pm Oct 9, 1939 Death is said to have occurred on the date stated above, at 9:30 a.m.  
 The principal cause of death and related causes of importance were as follows:  
Breast Cancer  
119 lb  
 Date of onset 9/12/39  
 Other contributory causes of importance:  
Splenophilia 2/10/38  
Gastro-intestines 10/2/39  
 Name of operation \_\_\_\_\_ Date of \_\_\_\_\_  
 What test confirmed diagnosis? X-ray 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? \_\_\_\_\_  
 If so, specify \_\_\_\_\_  
 (Signed) Paul Brown M. D.  
 (Address) Jefferson city, Mo.

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, .....

*D. M. Davis*

....., or by .....

Registered Apprentice No....., working under my personal supervision.

Signed.....

*D. M. Davis*

Licensed Embalmer No. *3741*

P. O. Address *Jefferson City 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 this body is not embalmed, above space should be left blank.**