

APR JUN 22 1940

18841

No. 11-13.3

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. ~~14~~

X21492

Registration District No. 466

Primary Registration District No. 4279

Registrar's No. 14

1. PLACE OF DEATH

(a) County Lafayette

(b) City or town Wellington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community _____
years, months or days (in 20)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lafayette

(c) City or town Wellington
(If outside city or town limits, write "RURAL")

(d) Street No. _____ (If rural, give location)

(e) If foreign born, how long in U. S. A? _____ years.

3. (a) PRINT / FULL NAME CARRIE-S. CREWS

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex Female 5. Color or race White

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Edward

6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased April 17 - 1878
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

61 11 26 hr. min.

9. Birthplace Wellington Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation House work 0

11. Industry or business same

12. Name Fred Gausman 6

13. Birthplace St Charles Co. Mo 6
(City, town, or county) (State or foreign country)

14. Maiden name Christine Kulchman

15. Birthplace Germany _____
(City, town, or county) (State or foreign country)

16. (a) Informant W. E. Crews

(b) Address Wellington Mo

17. (a) _____ (b) Date thereof April 15 1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Wellington Mo

18. (a) Signature of funeral director W. E. Crews 4/15

(b) Address Wellington Mo

19. (a) June 30 (b) 1890 F.H. Mason
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 12
year 1940 hour 9:30 minute _____ P. M.

21. I hereby certify that I attended the deceased from April 12 - 1940
19 _____ to April 12 1940 19 40
that I last saw her alive on April 12 1940 19 40
and that death occurred on the date and hour stated above.

Immediate cause of death burned to death by clothing catching fire from gasolene stove

Due to gasolene stove ✓

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: _____
Of operations _____

Of autopsy _____

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence April 12th 1940

(c) Where did injury occur? Wellington Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?
In Home

While at work? Y (Specify type of place) (e) Means of injury

23. Signature R. B. Watts (M. D. or other) 1

Address Wellington Mo Date signed April 15 1940

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

151
151

RECEIVED
District Health Officer No. 8
District File Number
Date Filed 6-11-9

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

Signed W. P. Owen
Licensed Embalmer No. 3070
P. O. Address Wellington, 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.

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BUREAU OF THE CENSUS

State File No. 18841

Registration District No. 466

Primary Registration District No. 4279

Registrar's No. 14

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County Lafayette
(b) City or town Wellington
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ (Specify whether)
years, months or days

3. (a) PRINT FULL NAME Carrie S. Crews

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ years

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years 61 Months 11 Days 26 If less than one day _____ min.

9. Birthplace (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name _____

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name _____

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (If outside city or town limits write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

19. MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 12 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19 _____ to _____ 19 _____; that I last saw him _____ alive on _____ and that death occurred on the date and hour stated above.

Immediate cause of death Burned to death by clothing catching on fire from Gasoline Stove
Due to No conflagration, she
Due to rare apt door's and
burned in the yard!
Other conditions _____ (Include pregnancy within 3 months of death)

Major findings: Of operations 181

Of autopsy 15

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place) _____ (c) Means of injury _____

23. Signature B. B. Watts (M. D. or other) _____
Address Wellington Mo Date signed _____

SUPPLEMENTARY

S-18841