

Registration District No. 548.

Primary Registration District No. 4323.

Registrar's No. 38.

1. PLACE OF DEATH: Marion
 (a) County.....
 (b) City or town Palmyra
 (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) 2
 (d) Length of stay: In hospital or institution..... (Specify whether
 In this community..... 5 years
 years, months or days)

3. (a) PRINT FULL NAME Nannie Howe Crane 1050
 3. (b) If veteran, name war..... 3. (c) Social Security No.....

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Widowed
 6. (b) Name of husband or wife John W. Crane 6. (c) Age of husband or wife if alive..... years
 7. Birth date of deceased August 16 1873
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 25 hr. min.

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

10. Usual occupation At Home

11. Industry or business.....

12. Name Thomas J. Simmons
 13. Birthplace Philadelphia Missouri
 (City, town, or county) (State or foreign country)

14. Maiden name Selma J. Young

15. Birthplace No record
 (City, town, or county) (State or foreign country)

16. (a) Informant Lorene C. Fountain
 (b) Address Palmyra, Mo.

17. (a) Burial (b) Date thereof 7/14/40
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Philadelphia, Mo.

18. (a) Signature of funeral director Lewis Prod
 (b) Address Palmyra, Mo.

19. (a) July 13 1940 (b) Certhude Lee
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Missouri (b) County Marion
 (c) City or town Palmyra
 (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.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 11
 year 1940 hour 6 minute 00 a.m.

21. I hereby certify that I attended the deceased from July 9
, 1940, to July 11, 1940
 that I last saw h..... alive on, 19.....;
 and that death occurred on the date and hour stated above.

Immediate cause of death Common Bile Duct Obstruction

Due to Carcinoma

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).....
 (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?

440
 While at work? (Specify type of place) (e) Means of injury.....

23. Signature W. J. Hill (M. D. or other) MD
 Address Palmyra Date signed 7/12/40

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

4
2
3

25

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

Bob Lewis

Licensed Embalmer No. 2382

P. O. Address.....Palmyra, 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, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

State File No. **25-724**

Registration District No. **548**

Primary Registration District No. **4323**

Registrar's No.

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

1. PLACE OF DEATH:

(a) County **Madison**
(b) City or town **Palmyra**
(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)

3. (a) PRINT FULL NAME **Nannie Howe Crane**

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

4. Sex **F** 5. Color or race **W** 6. (a) Single, widowed, married, divorced, **wid**

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

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

8. AGE: Years Months Days If less than one day
66 10 25 hr. 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) (Burial, cremation, or removal) (b) Date thereof. (Month) (Day) (Year)

(c) Place: burial or cremation.

18. (a) Signature of funeral director.

(b) Address.

19. (a) (Date received local registrar) (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.

3. MEDICAL CERTIFICATION

20. DATE OF DEATH. Month **July** day **11** year **1940** hour minute M.

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

Immediate cause of death **common bile duct obstruction** Duration **3 wks**

Carcinoma

Due to **Carcinoma probably of head of pancreas.**

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

Major findings: Of operations. **46**

Of autopsy. **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?

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

23. Signature (M. D. or other)

Address Date signed

SUPPLEMENTARY

