

No. 2
1-18-40
17-39
X23159

STANDARD CERTIFICATE OF DEATH

4468

State File No.

FILED FEB 18 1941

Registration District No. 799

Primary Registration District No. 4479

Registrar's No. 3

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

1. PLACE OF DEATH: **Saline**
 (a) County **Slater**
 (b) City or town **Slater**
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: **none**
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **all his life** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Clarence Odell Cross**

3. (b) If veteran, name war **World** 3. (c) Social Security No. **494-14-9929**

4. Sex **male** 5. Color or race **white** 6. (a) ~~Single~~ ~~widowed~~ ~~divorced~~ **married**

6. (b) Name of husband or wife **Myrtle Cross** 6. (c) Age of husband or wife if alive **42** years

7. Birth date of deceased **1-25-1895** (Month) (Day) (Year)

| | | | | |
|---------|-----------|----------|-----------|----------------------|
| 8. AGE: | Years | Months | Days | If less than one day |
| | 45 | 2 | 27 | |
| | | | | hr. min. |

9. Birthplace **Gilliam Mo. 0** (Give town, county) (State or foreign country)

10. Usual occupation **Carpenter**

11. Industry or business

12. Name **Andrew Cross**
13. Birthplace **Falls City, Neb. 1**

14. Maiden name **Lucy Highbarger**
15. Birthplace **Cooper Co. Mo. 0**

16. (a) Informant **Mrs. Myrtle Cross**
(b) Address **Slater, Mo.**

17. (a) **Slater** (b) Date thereof **1-24-1941** (Month) (Day) (Year)

(c) Place: burial or cremation **Hill Brothers**

18. (a) Signature of funeral director **Slater, Mo.**
(b) Address

19. (a) **J. L. H. H.** (b) **W. M. Tuttle** (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **Mo** (b) County **Saline 97**
 (c) City or town **Slater** (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 **Jan** day **22** year **1941** hour **7** minute **30 A.**

21. I hereby certify that I attended the deceased from **Slater** **Jan 22**, 1941, to _____, 19____; that I last saw _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

Immediate cause of death **Aneurysm of the ascending aorta!**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations

Of autopsy **as above**

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) (e) Means of injury _____

23. Signature **R. L. Lawless Coroner** (M. D. or other) **M. P.**
Address **Slater, Mo.** Date signed **1-22-41**

3090

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PAGE NO.

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.....

A. C. Hill

Licensed Embalmer No.....

3090

P. O. Address.....

Slater 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

State File No. 4468

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 799

Primary Registration District No. 4479

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Saline
(b) City or town States
(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

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. (a) PRINT FULL NAME Clarence Odell Cross

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

4. Sex Male 5. Color of white 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 Months Days If less than one day
45 2 27 hr. min.

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

10. Usual occupation.

11. Industry or business.

MOTHER FATHER { 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) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH. Month Jan day 22
year 1947 hour _____ minute _____ M.

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

Immediate cause of death aneurysm of the ascending aorta
Due to In my opinion due to syphilitic condition
Due to _____

Other conditions. (Include pregnancy within 3 months of death) 305

Major findings: Of operations _____
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? _____

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

23. Signature P. L. Lawler, Coroner (M. D. or other) _____
Address Mass. R. Rd Date signed SE-1-47

SUPPLEMENTARY

