

No. 2
-1-4-41
5-17-39
X26390

MAY 21 1941

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 15466

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 141

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

1. PLACE OF DEATH:

(a) County Pettis

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

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

(d) Length of stay: In hospital or institution 2 months
(Specify whether years, months or days)

In this community nine years

3. (a) PRINT FULL NAME Aaron L. Crain

3. (b) If veteran, name war none

3. (c) Social Security No. none

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Mrs. Nancy Crain

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

7. Birth date of deceased August 29, 1856
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>84</u>	<u>7</u>	<u>25</u>hr.min.

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

Retired

10. Usual occupation Retired

11. Industry or business M.K.T. Railroad

12. Name William S. Crain

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

14. Maiden name Mary Fullbright

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

16. (a) Informant Mrs. D.H. Hanson

(b) Address 1900 South Harrison (Daughter)

17. (a) Burial
(Burial, cremation, or removal)

(b) Date thereof 4/26/41
(Month) (Day) (Year)

(c) Place: burial or cremation Walnut Grove Boonville, Missouri

18. (a) Signature of funeral director Duane Furing

(b) Address Sedalia, Missouri

19. (a) 4/25/41
(Date received local registrar)

(b) Mrs. Harry Sued
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri

(b) County Pettis

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

(d) Street No. 1900 South Harrison
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 24
year 1941 hour 12 minute 30 a.m.

21. I hereby certify that I attended the deceased from 2-8-1940 to 4-23-1941
that I last saw him alive on 4-23-1941 and that death occurred on the date and hour stated above.

Immediate cause of death Neuropharyngeal Stenosis Carcinoma Throat

Due to _____

Due to _____

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

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 Alfred E. Hanson (M. D. or other) _____

Address 111 W 9 Sedalia, Mo Date signed 4-24-41

REC'D

RECEIVED
District Health Officer No. 8,
District File Number 5-19-41
Date Filed 5-19-41

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 *John E. Myers*
Licensed Embalmer No. *53220*
P. O. Address *Seaside, In*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete 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. 15466

Registration District No. 668

Primary Registration District No. 3032

Registrar's No. 181

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

1. PLACE OF DEATH:

(a) County Pettis
(b) City or town Sedalia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: paid by PENSION
1728 E. 5th Commercial Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 mo.
(Specify whether
In this community _____
years, months or days)

3. (a) PRINT FULL NAME Aaron L. Crain

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

4. Sex M 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 _____ year

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

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (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) Citizen of foreign country _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 24
year _____ hour _____ minute _____ M.

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

Due to _____
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? _____

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

SECRET

S-15466