DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 21 1942

Registration District No. 125

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 13900

Primary Registration District No. 3009

Registrar's No. 127

**1. PLACE OF DEATH:**

(a) County: Cape Girardeau

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

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

(d) Length of stay: In hospital or institution: 10 minutes (Specify whether years, months or days)

In this community: 2 yrs

**2. USUAL RESIDENCE OF DECEASED:**

(a) State: Missouri (b) County: Cape Gir Co.

(c) City or town: Cape Girardeau Mo. (If outside city or town limits, write "RURAL")

(d) Street No.: 225 N. Spring (If rural, give location)

(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME: Zula Crites

3. (b) If veteran name war: —

3. (c) Social Security No.: —

4. Sex: Female

5. Color or race: W

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

6. (b) Name of husband or wife: Lester Crites

6. (c) Age of husband or wife if alive: 35 years

7. Birth date of deceased: Don't Know (Month) (Day) (Year)

8. AGE: Years: 32 Months: Days: If less than one day: hr. min.

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

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Don't Know

FATHER 13. Birthplace: Don't Know (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: Don't Know

MOTHER 15. Birthplace: Don't Know (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Lester Crites

(b) Address: Cape Girardeau Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 4-26-42 (Month) (Day) (Year)

(c) Place: burial or cremation: Sargents Chapel

18. (a) Signature of funeral director: J. A. Lough Funeral Home

(b) Address: Cape Girardeau Mo

19. (a) 4-28-42 (Date received local registrar) (b) F. W. Phelps (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month April day 26th. year 1942 hour 3: minute 30 a. 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: Suicide by poison.

Due to: Carbolic Acid taken internally.

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? (Specify type of place)

While at work? (e) Means of injury:

23. Signature: Dr. J. F. Sigmund Coroner (M. D. or other)

Address: Jackson Mo. Date signed 4/26-42

(Licensed Embalmer's Statement on Reverse Side)

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very i

Rev. 5-17-39 Form 1 X19511

NOV 22 1949

JAN 13 1949

RECEIVED
District Health Officer No. 4
District File Number 542-69
Date Filed 5-19-42

## 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. H. Estes

Licensed Embalmer No. 3568

P. O. Address Cape Girardeau 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.**

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

# STANDARD CERTIFICATE OF DEATH

State File No. 13900

Registration District No. ____ Primary Registration District No. 3009 Registrar's No. ____

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

**1. PLACE OF DEATH:**
(a) County: Cape Girardeau
(b) City or town: Cape Girardeau (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. Francis Hosp (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 10 min (Specify whether years, months or days) In this community 2 yrs.

**2. USUAL RESIDENCE OF DECEASED:**
(a) State: Mo (b) County: Cape Girardeau
(c) City or town: Cape Girardeau (If outside city or town limits, write "RURAL")
(d) Street No.: 225 N. Spring (If rural, give location)
(e) Citizen of foreign country? ____ (Yes or No)
If yes, name country ____

3. (a) PRINT FULL NAME: Zula Critis
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: M
6. (b) Name of husband or wife ____ 6. (c) Age of husband or wife if alive ____ years
7. Birth date of deceased: unknown (Month) (Day) (Year)
8. AGE: Years 32 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 ____
FATHER 12. Name ____ 13. Birthplace (City, town, or county) (State or foreign country)
MOTHER 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)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month apr Day 26 year 1942 hour 3 minute 30 a.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.

| | Duration |
|---|---|
| Immediate cause of death: Suicide by poison | |
| Due to: Carbolic acid taken internally | |
| 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): Suicide
(b) Date of occurrence: April 26, 1942
(c) Where did injury occur? Cape Girardeau (City or town) Cape (County) Mo (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? On Independence St. 538 (Specify type of place)
While at work? No (e) Means of injury: Carbolic Acid
23. Signature: Dr. J. F. Sigmund Coroner (Mr. Dr. or other)
Address: Jackson, Mo. Date signed 6/1/42

SUPPLEMENTARY

1637