S. No. 2
M—1-4-41
. 5-17-39
I X26390

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1942

Registration District No. 3426

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3030

State File No. 14964

Registrar's No. 24

1. PLACE OF DEATH:

(a) County MISSISSIPPI

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

(c) Name of hospital or institution: 210 VINE STREET
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community ALL OF LIFE

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County MISSISSIPPI

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

(d) Street No. 210 VINE STREET
(If rural, give location)

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

If yes, name country NO

3. (a) PRINT FULL NAME MARCELLUS CRUSE

3. (b) If veteran, name war NO

3. (c) Social Security No. 488-01-3892

4. Sex MALE

5. Color or race COLOR

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

6. (b) Name of husband or wife DIVORCED

6. (c) Age of husband or wife if alive NO years

7. Birth date of deceased JANUARY (Month) 16 (Day) 1906 (Year)

8. AGE:

Years	Months	Days	If less than one day
36	1	22	..... hr. ..... min.

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

10. Usual occupation FURNITURE STORE ASSISTANT

11. Industry or business FRANK LAIR COMPANY

FATHER
12. Name ALBERT CRUSE (dec'd)
13. Birthplace BELMONT (City, town, or county) MISSOURI (State or foreign country)

MOTHER
14. Maiden name DELLA STANLEY
15. Birthplace WOLF ISLAND (City, town, or county) MISSOURI (State or foreign country)

16. (a) Informant MRS DELLA MEANS

(b) Address 210 VINEST, CHARLESTON, MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 3-10-42 (Month) (Day) (Year)

(c) Place: burial or cremation OAK GROVE, CHARLESTON, MO

18. (a) Signature of funeral director John F. Nunnelee Jr

(b) Address Charleston, MO

19. (a) 3-11-42 (Date received local registrar) (b) F. S. Vernon (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month MARCH day 8TH year 1942 hour 8 minute A M.

21. I hereby certify that I attended the deceased from Mar. 13, 1941, to Mar. 8, 1942 that I last saw h..... alive on ....., 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Pulmonary tuberculosis	1 yr
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

13 P

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 William L. Davis (M. D. or other) MD

Address Charleston Mo Date signed 3-10-42

745

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 442-496
Date Filed 4-13-42

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 John F. Nunnelee Jr

Licensed Embalmer No. 3851

P. O. Address Charleston

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.