

FILED MAY 21 1942

Registration District No. 773

Primary Registration District No. 4464

Registrar's No. 42

1. PLACE OF DEATH:

(a) County: St. Francois Co  
(b) City or town: Farmington  
(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 \_\_\_\_\_  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State: N.Y. (b) County: St. Francois  
(c) City or town: Farmington  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? no. (Yes or No)  
If yes, name country: \_\_\_\_\_

3. (a) PRINT-FULL NAME:

Benny DeLoe Crites  
3. (b) If veteran, name war: \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex: male 5. Color or race: W 6. (a) Single, widowed, married, divorced: W

6. (b) Name of husband or wife: \_\_\_\_\_ 6. (c) Age of husband or wife if alive: \_\_\_\_\_ years

7. Birth date of deceased: Dec. 30 1941  
(Month) (Day) (Year)

8. AGE: Years 1 Months 10 Days 5 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace: Farmington, Mo St. Fran Co  
(City, town, or county) (State or foreign country)

10. Usual occupation: \_\_\_\_\_

11. Industry or business: \_\_\_\_\_

12. Name: Monroe Crites

13. Birthplace: Tryville Bollinger Co  
(City, town, or county) (State or foreign country)

14. Maiden name: Mable Johnson

15. Birthplace: St. Louis Mo  
(City, town, or county) (State or foreign country)

16. (a) Informant: Monroe Crites father

(b) Address: Farmington

17. (a) Burial (b) Date thereof: April 7-1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation: Parkview Cem.

18. (a) Signature of funeral director: Copps Funeral Home

(b) Address: Farmington

19. (a) 4-7-42 (b) Byrdie S. Buhmester  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 5  
year 1942 hour 4 minute 5:2 A.M.

21. I hereby certify that I attended the deceased from April 3  
3:00 1942 to April 5 1942  
that I last saw him alive on April 5 1942  
and that death occurred on the date and hour stated above.

Immediate cause of death: Bronchopneumonia  
Duration: 2 days

Due to: \_\_\_\_\_

Due to: \_\_\_\_\_

Other conditions: \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations: \_\_\_\_\_

Of autopsy: No

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: L. M. Stanfield (M. D. or other) MD

Address: Farmington Date signed: 4/7/42

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4  
District File Number 542-578  
Date Filed 5-13-42

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.....

me....., Registered Apprentice No.....  
working under my personal supervision.

Signed

C. A. Corcoran  
Licensed Embalmer No. 4084

P. O. Address Farmington, 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. 15-329

Registration District No. 773

Primary Registration District No. 4464

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH

(a) County St. Francois  
(b) City or town Farmington  
(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 \_\_\_\_\_ years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County St. Francois  
(c) City or town Farmington  
(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 \_\_\_\_\_

3. (a) PRINT FULL NAME Nancy L. Crites  
3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month April Day 5 year 1942 hour 4 minute 30 A.M.  
21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_; that I last saw him \_\_\_\_\_ live on \_\_\_\_\_ 19\_\_\_\_; and that death occurred on the date and hour stated above. Immediate cause of death Broncho pneumonia

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced \_\_\_\_\_  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years  
7. Birth date of deceased Dec-30-1904  
(Month) (Day) (Year)

Due to measles during pneumonia  
Due to \_\_\_\_\_  
Other conditions \_\_\_\_\_ (Include pregnancy within 3 months of death)  
Major findings: Of operations 35  
Of autopsy \_\_\_\_\_

8. AGE: Years 1 Months 3 Days 30 (If less than one day in 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)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_ (Registrar's signature)

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 L. M. Stauffer (M. D. or other) MD  
Address Farmington, Missouri Date signed \_\_\_\_\_

Duration \_\_\_\_\_  
PHYSICIAN \_\_\_\_\_  
Underline the cause to which death should be charged statistically.

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

SUPPLEMENTARY

