

JUN 10 1942

Registration District No. 117

Primary Registration District No. 5170

Registrar's No. 19

1. PLACE OF DEATH:

(a) County Camden

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

(c) Name of hospital or institution: St. Joseph's Hospital
1 Sun. Ben Del. Hwy
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community life
years, months or days _____

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Camden

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

(d) Street No. Ben Del.
(If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME Joseph Crall

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

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

6. (b) Name of husband or wife Emma Kane 6. (c) Age of husband or wife if alive 62 years

7. Birth date of deceased: Nov (Month) 16 (Day) 1876 (Year)

8. AGE: Years 65 Months 5 Days 20 If less than one day _____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Samuel Crall

13. Birthplace Penn (State or foreign country)

14. Maiden name Mary Jane Shaw

15. Birthplace Ohio (State or foreign country)

16. (a) Informant Stover Crall

(b) Address Deatonville, mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 7 - 42 (Month) (Day) (Year)

(c) Place: burial or cremation High Point Cem

18. (a) Signature of funeral director Burkhan - Woalery

(b) Address Camden, mo

19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 6th year 1942 hour 12th minute 45 AM

21. I hereby certify that I attended the deceased from July 15, 1941 to May 6, 1942
that I last saw him alive on May 5, 1942
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage Duration 2 days

Due to arteriosclerosis 2 years

Due to _____

Other conditions (Include pregnancy within 3 months of death) 8301

Major findings: Of operations none

Physician _____

Underline the cause to which death should be charged statistically.

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) (c) Means of injury _____

23. Signature Myron D Jones (M.D. or other) DO

Address Burkley, mo Date signed 5-19-42

1153

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

005

RECEIVED

District Health Officer No. 7,

District File Number 6-42-620

Date Filed 6-9-42,

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

Abbie Banksen Woolf

Licensed Embalmer No. 2488

P. O. Address Camdenton,

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. 17621
Registrar's No. 19

Registration District No. 117

Primary Registration District No. 5170

1. PLACE OF DEATH: Camden Rural

(a) County.....
 (b) City or town.....
 (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)

3. (a) PRINT FULL NAME: Joseph Corall

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..... years

7. Birth date of deceased: Nov. 16 1872
 (Month) (Day) (Year)

8. AGE: Years 65 Months 5 Days 16 If less than one day in 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.....
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation.....

18. (a) Signature of funeral director.....
 (b) Address.....

19. (a) May 9, 45 (b) La Verne Hoskins
 (Date of 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 May Day 12 year 1942 hour..... minute..... M.

21. I hereby certify that I attended the deceased from..... 19.....
 that I have seen him/her live on..... 19.....
 and that death occurred on the date and hour stated above.

Immediate cause of death.....
 Duration.....
 Due to.....
 Due to.....
 Other conditions.....
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings:
 Of operations.....
 Of autopsy.....
 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..... (M. D. or other).....
 Address..... Date signed.....

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

SUPPLEMENTARY

