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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____
Registrar's No. 3918

Registration District No. 318

Primary Registration District No. 1003

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

1. PLACE OF DEATH:

(a) County ST LOUIS

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

(c) Name of hospital or institution:
BARNES HOSPITAL
(If not in hospital or institution, write street number or location)

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

In this community _____ (Specify whether _____)
years, months or days

3. (a) PRINT FULL NAME RALPH CRANDALL

3. (b) If veteran, name war _____

3. (c) Social Security No. NONE

4. Sex M 5. Color or race W

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

6. (b) Name of husband or wife MARY AGNES CRANDALL

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

7. Birth date of deceased OCT. 25 1885
(Month) (Day) (Year)

8. AGE: Years 57 Months 6 Days 1 If less than one day _____ hr. _____ min.

9. Birthplace LEWISTOWN MO
(City, town or county) (State or foreign country)

10. Usual occupation FARMER

11. Industry or business _____

FATHER
MOTHER

12. Name JIM CRANDALL

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

14. Maiden name LYDIA A HINKLE

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

16. (a) Informant MRS MARY A CRANDALL

(b) Address LEWISTOWN, MO

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 4-29-43
(Month) (Day) (Year)

(c) Place: burial or cremation LEWISTOWN, MO

18. (a) Signature of funeral director ALBERT H. HOPPE

(b) Address 4700 WASHINGTON BLDG

19. (a) APR 27 1943 (Date received local registrar) (b) J. F. Prodesch (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LEWIS

(c) City or town LEWISTOWN
(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 26
year 1943 hour 6 minute 40 P.M.

21. I hereby certify that I attended the deceased from APR. 26, 1943 to APR. 26, 1943;
that I last saw him alive on APR. 26, 1943,
and that death occurred on the date and hour stated above.

Immediate cause of death Monocytic leukemia Duration 2

Due to _____

Due to _____

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

Major findings:
Of operations _____

Of autopsy Leukemia type undetermined; Bronchopneumonia, bilateral

Underline the cause to which death could 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. C. Abney, M.D. (M. D. or other) #
Address BARNES HOSPITAL Date signed 4/27/43

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JULY 18 1943

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 J. Allen Davis Jr
Licensed Embalmer No. 4053

P. O. Address.....

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.