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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED SEP 13 1943

Registration District No. 363

Primary Registration District No. 6196

Registrar's No. 20

1. PLACE OF DEATH:

(a) County Texas
(b) City or town Rural Shenell Texas
(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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Joseph G Crow

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

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

6. (b) Name of husband or wife Lucy Crow 6. (c) Age of husband or wife if alive 65 years

7. Birth date of deceased Aug 22 1874
(Month) (Day) (Year)

8. AGE: Years 68 Months 11 Days 4 If less than one day _____ hr. _____ min.

9. Birthplace Kamble Mo 0
(City, town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business Le Roy S. Crow

12. Name Le Roy S. Crow 13. Birthplace Kamble Mo 0
(City, town, or county) (State or foreign country)

14. Maiden name Margaret Anderson

15. Birthplace W. W. Brown Ky 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Samantha Dole
(b) Address Salem Mo

17. (a) Burial (b) Date thereof July 27 43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Shenell Texas

18. (a) Signature of funeral director John T. Ferguson
(b) Address Licking Mo

19. (a) Aug 26 - 43 (b) Maggie Wilson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. 15 Miles west of Maple Mo.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 26
year 1943 hour 12 minute 350 M.

21. I hereby certify that I attended the deceased from July 1946 to July 25 1945
that I last saw him alive on July 1945
and that death occurred on the date and hour stated above.

Immediate cause of death apoplexy

Due to Chronic Hypertension

Due to _____

Other conditions (Include pregnancy within 3 months of death) 131 lb

Major findings: Of operations _____

Of autopsy _____

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)

23. Signature Leslie Parrott M.D. (M. D. or other)

Address Licking Mo Date signed _____

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1237

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. E.

District File No. 943 556

Date Filed 9-11-43

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 *Hubert E Ferguson*

Licensed Embalmer No. *13945*

P. O. Address *Fishing 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.