

RECEIVED OCT 11 1943 70  
Registration District No. 370

Primary Registration District No. 6255

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

1. PLACE OF DEATH:

(a) County Wayne  
(b) City or town Bonbank  
(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 1  
In this community Lifetime (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Wayne  
(c) City or town Bonbank  
(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 COLEMAN HASTAL CRITES

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 1

6. (b) Name of husband or wife Gene Crites 6. (c) Age of husband or wife if alive 72 years

7. Birth date of deceased Oct 8 1872  
(Month) (Day) (Year)

8. AGE: Years 70 Months 11 Days 14 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation farmer

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

12. Name Alfred Crites

13. Birthplace Bonbank Missouri  
(City, town, or county) (State or foreign country)

14. Maiden name Bonbank Missouri  
(City, town, or county) (State or foreign country)

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

16. (a) Informant J. C. Crites

(b) Address Bonbank

17. (a) Burial (b) Date thereof Sept 25 1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cross Roads National Funeral Home

18. (a) Signature of funeral director Gene Bennett  
(b) Address Loueville Mo.

19. (a) 9-30-1943 (b) Gene Bennett  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 22  
year 1943 hour 13 AM minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Aug 1 1943 to Sept 23 1943

that I last saw him alive on Sept 14 1943 and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Stenosis

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

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

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

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) (e) Means of injury \_\_\_\_\_

23. Signature Adam F. Wagoner (M.D. or other) M.D.  
Address Greenville Mo. Date signed Oct 1

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1222

1943

RECORDED

District Health Officer No. 4  
District File Number 1043-2839  
Date Filed 10-9-43

**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.....

Licensed Embalmer No.....

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.**