

FILED DEC 17 1943

State File No. _____

Registration District No. 295

Primary Registration District No. 6012

Registrar's No. 64

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

1. PLACE OF DEATH:

(a) County Randolph

(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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

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

(d) Street No. North Maine
(If rural, give location)

(e) Citizen of foreign country? no (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Charles Frederick Crist

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

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

6. (b) Name of husband or wife Sadie Crist 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 9 1875
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>68</u>	<u>2</u>	<u>23</u>	hr. _____ min.

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

10. Usual occupation Insurance business

11. Industry or business _____

12. Name Joseph W. Crist

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

14. Maiden name Nancy Merrick

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

16. (a) Informant Mrs. Sadie Crist

(b) Address Huntsville, Missouri

17. (a) burial (b) Date thereof 11/5/1943
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Huntsville Cemetery

18. (a) Signature of funeral director Tom P. Patton

(b) Address Huntsville Mo

19. (a) 11-30-43 (b) Mrs. P. D. Meyer
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 2nd
year 1943 hour 6 minute 30 P.M.

21. I hereby certify that I attended the deceased from 11/1/43
1942 to Nov. 2 1943

that I last saw him alive on _____ 19____
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Angina Pectoris Sudden

Due to 94 P

Due to Arterial Hypertension Several yrs.

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

PHYSICIAN _____

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 D. H. Johnston (M. D. or other) Dr.
Address Huntsville Date signed 11/29/43

RECEIVED

District Health Officer No: 10

District File Number 12-43-1994

Date Filed DEC 15 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 Tom B Patton

Licensed Embalmer No. 3914

P. O. Address Huntsville, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. *Jan*
Registrar's No. *64*

Registration District No. *295* Primary Registration District No. *6012*

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

1. PLACE OF DEATH:

(a) County *Randolph*

(b) City or town *Rural - Chariton*
(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 *Charles F. Crist*

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 *aug 9 1923*
(Month) (Day) (Year)

8. AGE: Years *68* Months *2* Days *23* (less than one day) _____ 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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) *Mrs. P. O. Dreyer*
(Date received 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 *Nov* Day *2*
Year *1943* Hour _____ Minute _____ M.

21. I hereby certify that I attended the deceased from _____
to _____
that I last saw him alive 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)

Major findings:
Of operations _____

Of autopsy _____

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 _____ (M. D. or other) _____

Address _____ Date signed _____

SUPPLEMENTARY

5-13475