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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 JAN 5 1944

Registration District No. 361

Primary Registration District No. 6230

Registrar's No. _____

1. PLACE OF DEATH:

(a) County VERNON
(b) City or town NEAR Rich Hill Mo.
(c) Name of hospital or institution: 1 mi. S.W.
(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 Mo (b) County Vernon
(c) City or town Rural Rich Hill Mo.
(If outside city or town limits, write "RURAL")
(d) Street No. 2 mi. S.W. (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME JOHN POLK CRANE

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 W
6. (b) Name of husband or wife SARAH CRANE 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased FEB 13 1865 (Month) (Day) (Year)

8. AGE: Years 78 Months 00 Days 14 If less than one day hr. _____ min.

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

10. Usual occupation FARMER

11. Industry or business _____

12. Name JOHN P. CRANE
13. Birthplace LAFAYETTE Co. Mo. (City, town, or county) (State or foreign country)
14. Maiden name MARGARET SELF
15. Birthplace LAFAYETTE Co. Mo. (City, town, or county) (State or foreign country)

16. (a) Informant Wm. R. Green

(b) Address Rural Rich Hill Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-29-43 (Month) (Day) (Year)

(c) Place: burial or cremation Carson Center Cemetery

18. (a) Signature of funeral director Booth

(b) Address Rich Hill Mo

19. (a) Dec 30, 1943 (Date received local registrar) (b) Marcell L. Charles (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec day 27 year 1943 hour 9:05 minute P M.

21. I hereby certify that I attended the deceased from Oct 5 1943 to Dec 27 1943; that I last saw him alive on Dec 27 1943; and that death occurred on the date and hour stated above.

Immediate cause of death Quiescent Pulmonary
Due to degenerative 1 yr

Other conditions (Includes pregnancy within 3 months of death) 13/10

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 [Signature] (M. D. or other) _____
Address _____ Date signed 1/2/44

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

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

1221

RECEIVED

Director of Health Office No. 71

Department of Health

12-43-1319
1-3-4#

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.