

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

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED APR 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

10969

State File No. \_\_\_\_\_  
Registrar's No. 201A

Registration District No. 128

Primary Registration District No. 5465

1. PLACE OF DEATH:

(a) County Greene  
(b) City or town Rural, N. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Route #2  
(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 Greene  
(c) City or town Rural, N. Campbell Twp.  
(If outside city or town limits, write "RURAL" and name of township)  
(d) Street No. \_\_\_\_\_ (If rural, give location) Road 2  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Gronner Rice Crosby

3. (b) If veteran, name war WWI  
3. (c) Social Security No. None

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Ida 6. (c) Age of husband or wife if alive Unknown years  
7. Birth date of deceased Dec. 22, 1867  
(Month) (Day) (Year)

8. AGE: Years 82 Months 2 Days 4 hr. \_\_\_\_\_ min. \_\_\_\_\_  
If less than one day

9. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

10. Usual occupation Farming

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

12. Name Earl Crosby  
13. Birthplace W. Tennessee (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name Unknown  
15. Birthplace Unknown (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant Mrs. Ida Crosby  
(b) Address Springfield MO #2

17. (a) Burial (b) Date thereof Feb. 28-44  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Sanford Cemetery

18. (a) Signature of funeral director Alma Lohmeyer Funeral Home

(b) Address 534 ST. LOUIS STREET

19. (a) 3-29-44 (b) Springfield, Missouri  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb. day 26  
year 1944 hour 5:00 minute A. M.

21. I hereby certify that I attended the deceased from Dec 17, 1943 to Feb. 25, 1944  
that I last saw him alive on Feb. 25, 1944  
and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Nephritis  
Atherosclerosis  
Myocardial Degeneration  
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 R. F. Foelt (M. D. or other) MD  
Address Springfield Mo Date signed 3/27/44

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

**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 Harlow Knabb

Licensed Embalmer No. 4065

P. O. Address Springfield

**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.**