

U.S. No. 2
FORM-2-43
Rev. 5-17-39
X35697

8979

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED APR 13 1945
Registration District No. 3-8

Primary Registration District No. 3.006

Registrar's No. 61

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: Ellis Pischel State Cancer Hospital
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 120 days
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Marion ⁸⁴

(c) City or town Palmyra ^(Rural)
(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 Eugene Robert Crane

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 20
year 1945 hour 12 minute 50 P.M.

21. I hereby certify that I attended the deceased from November 20, 1944, to March 20, 1945;

that I last saw him alive on March 20, 1945; and that death occurred on the date and hour stated above.

4. Sex Male

5. Color or race White

6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased August 23 1852
(Month) (Day) (Year)

Immediate cause of death General
Several failures

Due to Complication followin
Extensive cancer of left

Due to Buccal mucosa
cervical metastases - 6 mo.

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

8. AGE: Years 92 Months 6 Days 25
If less than one day hr. _____ min. _____

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

10. Usual occupation Laborer

Major findings: Of operations _____

Of autopsy _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business _____

12. Name John Crane

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

14. Maiden name Martha Crain

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

16. (a) Informant Thomas J. Crane (cousin of pt.)

(b) Address Philadelphia Mo.

17. (a) Removed (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Palmyra Mo.

18. (a) Signature of funeral director Parkhi

(b) Address Columbia Missouri

19. (a) 3-21-1945 (b) Edna H. Parkhi
(Date received local registrar) (Registrar's signature)

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 D

23. Signature R. J. Woodall (M. D. or other) _____
Address _____ Date signed _____

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

10
2
4

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 4-12-45

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 W. S. Whitaker

Licensed Embalmer No. 3893

P. O. Address Columbia, 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.