S. No. 2
M—2-43
5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 17 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12958

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 97

1. PLACE OF DEATH:

(a) County Butler
(b) City or town Poplar Bluff (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution Poplar Bluff Hosp 17 (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether
In this community 90 days years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Carter 18
(c) City or town Rural (If outside city or town limits, write "RURAL")
(d) Street No. X (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME U. S. CRANDALL

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 SINGLE
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased Jan (Month) 1 (Day) 1868 (Year)

8. AGE: Years 77 Months 2 Days 23 If less than one day hr. min.

9. Birthplace Berne (City, town, or county) Ind. (State or foreign country)
10. Usual occupation Dentist
11. Industry or business

FATHER
12. Name John L Crandall
13. Birthplace Maryland (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Nancy Ellen Jones
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Dorothy Chasten
(b) Address Arcadia Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-25-45 (Month) (Day) (Year)
(c) Place: burial or cremation Pleasant Lite
18. (a) Signature of funeral director Phil A Leuchel
(b) Address Van Buren Mo
19. (a) 4-4-45 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Mar day 23 year 1945 hour 4 minute 45 P.M.

21. I hereby certify that I attended the deceased from 2-1, 1944 to 3-23, 1945 that I last saw him alive on 3-23, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of head of pancreas

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 46 g

Major findings: Of operations Carcinoma of head of pancreas inoperable
Of autopsy Biopsy confirmed

Duration

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature [signature] (M. D. or other)
Address Poplar Bluff Mo Date signed 4-2-45

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(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No.
District File Number 445-2
Date Filed APR 11 1945

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~~ 3-24-45

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Philip A Leuchel

Licensed Embalmer No. 2936

P. O. Address Van Buren Fl

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.

No. 2B
—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No.

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 97

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County

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

(c) Name of hospital or institution: Poplar Bluff Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X 4 mo X (Specify whether

In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town X Van Buren — RURAL X (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

3. (a) PRINT FULL NAME U. S. Crandall

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

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

6. (b) Name of husband or wife

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

7. Birth date of deceased (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day or min.

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

10. Usual occupation

11. Industry or business

FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 4/13/45 (Date received local registrar) (b) Belle Kinnel (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 23 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19; that I last saw h alive on 19; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)

(b) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work? (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

12958