DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 15 1946

Registration District No. 170

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3033

Hope

41592

State File No.

Registrar's No.

1. PLACE OF DEATH:
(a) County LACLEDE
(b) City or town LEBANON
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: WALLACE HOSPITAL
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 DAYS (Specify whether years, months or days)
In this community 4 DAYS

2. USUAL RESIDENCE OF DECEASED:
(a) State MO (b) County Dr. TEXAS 109
(c) City or town PLATO 0
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 1
(e) Citizen of foreign country? NO (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME ELVIN FARRELL CRISMON
3. (b) If veteran, name war
3. (c) Social Security No. 491-24-2514

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 NOV (Month) 13 (Day) 1926 (Year)

8. AGE: Years 19 Months 1 Days 12 If less than one day hr. min.

9. Birthplace TEXAS Co (City, town, or county) MO 0 (State or foreign country)
10. Usual occupation CLERK IN P.X.
11. Industry or business
FATHER 12. Name VIRGIL R CRISMON 0
13. Birthplace Mo (City, town, or country) (State or foreign country)
MOTHER 14. Maiden name POLLY CHATHAM
15. Birthplace NEBO (City, town, or country) MO 0 (State or foreign country)
16. (a) Informant V. R. Crismon
(b) Address PLATO MO
17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 12-27-45 (Month) (Day) (Year)
(c) Place: burial or cremation CEDAR BLUFF
18. (a) Signature of funeral director PALMER'S
(b) Address LEBANON MO
19. (a) 12-30-45 (Date received local registrar) (b) Ora Frankeberger (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month DEC day 25 year 1945 hour 3 minute 55 A.M.
21. I hereby certify that I attended the deceased from 12/21, 1945, to 12/25, 1945, that I last saw h. ~~alive~~ alive on 12/25, 1945, and that death occurred on the date and hour stated above.

Immediate cause of death: acute nephritis — Duration 6 wks
Due to
Due to
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 0

23. Signature James L. Hope (M. D. or other)
Address Lebanon, Mo Date signed 12/29/45

(Licensed Embalmer's Statement on Reverse Side)

Received .....

Laclede County Health Unit

File No. 12-45-188

Date Filed 1/14/46

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 R A Palmer

Licensed Embalmer No. 1161

P. O. Address Lebanon Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

2B
-45
43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Jan

Registration District No. 170 Primary Registration District No. 3023 Registrar's No.

1. PLACE OF DEATH:

(a) County Laclede

(b) City or town Lebanon
(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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Elvin F. Crusman

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 S

6. (b) Name of husband or wife

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

7. Birth date of deceased Nov. 13 1926
(Month) (Day) (Year)

8. AGE: Years 19 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 5 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.

Immediate cause of death — Duration

Due to

Due to was said to have had scarlet fever

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? (Specify type of place)

While at work? (e) Means of injury

23. Signature James E. Hope (M. D. or other)

Address Lebanon, Mo. Date signed 1/16/46

SUPPLEMENTARY

41592