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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

42677

FILED JAN 5 1946
Registration District No. 348

Primary Registration District No. 4512

State File No. _____
Registrar's No. 85-

1. PLACE OF DEATH:
(a) County Sullivan
(b) City or town _____
(c) Name of hospital or institution: Country
(d) Length of stay: In hospital or institution _____
In this community life time years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Sullivan
(c) City or town Newtown Rural
(d) Street No. 3 Miles SE
(e) Citizen of foreign country? _____

3. (a) PRINT FULL NAME Esred LaViole Crane
3. (b) If veteran, name war _____ 3. (c) Social Security No. none

4. Sex 1 5. Color or race W 6. (a) Single widowed, married, divorced
6. (b) Name of husband or wife J. W. Crane 6. (c) Age of husband or wife if alive 72 years
7. Birth date of deceased 6 22 1875 (Month) (Day) (Year)

8. AGE: Years 68 Months 6 Days 19 If less than one day hr. _____ min. _____

9. Birthplace Newtown Mo (City, town, or county) (State or foreign country) 0

10. Usual occupation house wife

11. Industry or business _____

12. Name O. A. Reines
13. Birthplace Oregon
14. Maiden name Thomas Baldridge
15. Birthplace Indiana

16. (a) Informant J. W. Crane
(b) Address Newtown Mo

17. (a) Burial (b) Date thereof: _____ (Month) (Day) (Year)
(c) Place: burial or cremation Burial

18. (a) Signature of funeral director Julia Payne
(b) Address Newtown Mo

19. (a) _____ (b) Meta Caldwell
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ day _____ year _____ hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from Dec 3 1945 to Dec 1945
that I last saw her alive on Dec 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Cardiac failure
Lobar Pneumonia
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 G. Dale (M. D. or other) P.O.
Address Newtown Mo Date signed 12/13/45

Duration _____
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

1380

(Licensed Embalmer's Statement on Reverse Side)

APR 3 1947

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 *H. Howard Field*.....

Licensed Embalmer No. *3240*.....

P. O. Address: *Keeton In*.....

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.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATHState File No. *Jan 85*Registration District No. *348*Primary Registration District No. *4512*

Registrar's No. _____

1. PLACE OF DEATH

- (a) County *Sullivan*
- (b) City or town *Courtesy*
(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 _____)
- In this community _____
years, months or days

3. (a) PRINT FULL NAME *Estelle V. Crane*

3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex *female* 5. Color or race *w*
6. (a) Single, widowed, married, divorced *14*
6. (b) Name of husband or wife _____
6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased *June 22, 1885*
(Month) (Day) (Year)8. AGE: Years *68* Months _____ Days _____ If less than one day
hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

- MOTHER { 12. Name _____
- FATHER { 13. Birthplace _____ (City, town, or county) (State or foreign country)
14. Maiden name _____
15. Birthplace _____ (City, town, or county) (State or foreign country)

16. (a) Informant _____

(b) Address _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *Jan. 15-46* (b) *Erta Caldwell*
(Date received local registrar) (Registrar's signature)

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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____
Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____;

that I last saw him _____ alive on _____, 19____;

and that death occurred on the date and hour stated above.

Immediate cause of death _____

Duration

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)
- (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 _____ (M. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

42077