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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED JAN 25 1946

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

3150

State File No.

Registration District No. [illegible]

Primary Registration District No. [illegible]

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution: Residence
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ✓ (Specify whether
In this community Thirty five years
years, months or days)

2. USUAL RESIDENCE OF DECEASED: 55

(a) State Missouri (b) County Lawrence

(c) City or town Mt. Vernon R.R.
(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 Mary Corliss Crandall

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female

5. Color or race White

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

6. (b) Name of husband or wife ✓

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

7. Birth date of deceased 8 (Month) - 20 (Day) - 1860 (Year)

8. AGE:

Years	Months	Days	If less than one day
85	3	21	hr. min.

9. Birthplace New York (City, town, or county) State 1 (State or foreign country)

10. Usual occupation

11. Industry or business House-Keeper

FATHER
12. Name Gardner Corliss
13. Birthplace New York (City, town, or county) State 1 (State or foreign country)

MOTHER
14. Maiden name Esther
15. Birthplace New York (City, town, or county) State 1 (State or foreign country)

16. (a) Informant John Crandall
(b) Address Mt. Vernon Mo. R.R.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-14-1945 (Month) (Day) (Year)
(c) Place: burial ~~or cremation~~ Salem

18. (a) Signature of funeral director Morris - Leiman
(b) Address Miller Mo.

19. (a) 12/29/45 (Date received local registrar) (b) Dr R.R. Philbrick (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month 12 day 11
year 1945 hour 10 minute 30 P.M.

21. I hereby certify that I attended the deceased from Dec. 4, 1945 to Dec. 11, 1945
that I last saw her alive on Dec. 11, 1945
and that death occurred on the date and hour stated above.

Immediate cause of death Influenza — Duration 7 days

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy 33B

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 P A Holmes (M. D. ~~or other~~)
Address Mt Vernon Mo Date signed 12-20-45

159

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 6
District File Number 146-74
Date Filed JAN 22 1946

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 E. R. Leuman

Licensed Embalmer No. 3297

P. O. Address Miller 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.

No. 2B
M—3-45
P I X43880

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. Feb

Registration District No. 383 Primary Registration District No. 5655 Registrar's No. 62

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Rural - Mt Vernon Twp
(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 Mary C. Crandall

3. (b) If veteran, name war C

3. (c) Social Security No.

4. Sex F

5. Color or race W

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 Aug 20 1866
(Month) (Day) (Year)

8. AGE: Years 85 Months 3 Days If less than one day hr. min.

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

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) 12/29-45 (Date received local registrar) (b) D.R. Philbrick (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec Day 31 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 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? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

3150