

LED MAY 7 1946

Registration District No. **38**

Primary Registration District No. **3006**

Registrar's No. **88**

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:
Wilhite Convalescent Home 4
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **10 Days**
(Specify whether years, months or days)
 In this community **33 Years**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Boone** **10**
 (c) City or town **Columbia** **2**
(If outside city or town limits, write "RURAL")
 (d) Street No. **104 Ripley St.** **4**
(If rural, give location) **0**
 (e) Citizen of foreign country? **No** (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME **PEARL FRANCES CRUMP**

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

4. Sex **Female** / 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Single 0**

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

7. Birth date of deceased **7 - 15 - 1868**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	77	8	25	hr. _____ min. _____

9. Birthplace **Fayette Missouri 0**
(City, town, or county) (State or foreign country)

10. Usual occupation **Retired**

11. Industry or business _____

12. Name **John Crump**

13. Birthplace **Boone County Missouri 0**
(City, town, or county) (State or foreign country)

14. Maiden name **Frances Nichols**

15. Birthplace **Boone County Missouri 0**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Roy Brown**

(b) Address **Jefferson City, Mo.**

17. (a) **Burial** (b) Date thereof **4-11-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Columbia Cemetery**

18. (a) Signature of funeral director **Palmer Funeral Service**
Columbia, Mo.
 (b) Address _____

19. (a) **4-12-46** (b) **Mrs. R.E. Palmer**
(Date received local registrar) (Registrar's signature)

20. DATE OF DEATH: Month **April** day **10**
 year **1946** hour **6** minute **45** A.M.

21. I hereby certify that I attended the deceased from **December 19 1945** to **Apr. 6 1946**
 that I last saw her alive on **Apr. 6, 1946**
 and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Failure** Duration **10 days**

Due to **Chronic cardiovascular renal disease** } many years

Due to **arteriosclerotic heart disease** }

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

Major findings:
 Of operations _____
 Of autopsy **1310**

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 **Maurice E. Cooper** (M. D. or other) **M.D.**
 Address **Columbia, Mo.** Date signed **4/11/46**

31

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

11084

17-35
X37823

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-6-46

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..... *Tom M. Harg*.....
Licensed Embalmer No. *4067*.....
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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. Ma
Registrar's No. 886

Registration District No. 28 Primary Registration District No. 3006

1. PLACE OF DEATH:
(a) County Boone Columbia
(b) City or town _____
(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 Pearl J. Crump
3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced 5

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

7. Birth date of deceased July 15
(Month) (Day) (Year)

8. AGE: Years 77 Months 8 Days no (If less than one day) _____ hr _____ min.

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

10. Usual occupation _____

11. Industry or business _____

12. Name _____

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 _____ (Month) (Day) (Year)
(Burial, cremation, or removal) (Place: burial or cremation)

18. (a) Signature of funeral director _____ (b) Address _____

19. (a) 4-12-46 (b) Mrs R & Palmer
(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 July 10
year 1946 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 _____

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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

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

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

MOTHER FATHER

12175