

U. S. No. 2
FORM-8-43
Rev. 5-17-39
I X37823

UNITED STATES HEALTH DEPARTMENT
STANDARD CERTIFICATE OF DEATH

State File No. **12385**
Registrar's No. **130**

FILED MAY 4 1946
Registration District No. **47**

Primary Registration District No. **3008**

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

1. PLACE OF DEATH:

(a) County Callaway

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

(c) Name of hospital or institution: State Hospital no 1-2
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 22 yrs 5 months (Specify whether years, months or days)

In this community 22 yrs 5 months (Specify whether years, months or days)

3. (a) PRINT FULL NAME WILLIAM CRISWELL

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 mar /

6. (b) Name of husband or wife Annie Criswell 6. (c) Age of husband or wife if alive 29 years

7. Birth date of deceased Sept 14 1890
(Month) (Day) (Year)

8. AGE: Years 55 Months 8 Days 28 If less than one day hr. _____ min. _____

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

10. Usual occupation farm laborer

11. Industry or business farming

12. Name Holland Tally (If adopted by Criswell family)

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

14. Maiden name D K

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

16. (a) Informant Records

(b) Address _____

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-12-1946
(Month) (Day) (Year)

(c) Place: burial or cremation New Bloomfield Mo

18. (a) Signature of funeral director Ray A. Holt

(b) Address New Bloomfield Mo

19. (a) 4-12-1946 (Date received local registrar) (b) John M. ... (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Callaway

(c) City or town New Bloomfield (If outside city or town limits, write "RURAL")

(d) Street No. Route #1 (If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 11 year 1946 hour 9 minute 50 A M.

21. I hereby certify that I attended the deceased from April 10, 1946, to April 11, 1946; that I last saw him alive on April 11, 1946; and that death occurred on the date and hour stated above.

Immediate cause of death: Tuber pneumonia (terminal) Duration 10 hours

Due to chronic myocarditis 1 yr

Due to arteriosclerosis 4 yrs

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

Major findings: 938

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 0

23. Signature John M. ... (M. D. or other) 4/11/46

Address Fulton Mo Date signed 4/11/46

RECEIVED

District Health Officer No. 9,

District File Number.....

Date Filed 5-7-46

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 Roy Clayton

Licensed Embalmer No. 4412

P. O. Address New Bloomfield

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.