

S. No. 2
A-12-45
7-5-17-39
I X47070

FILED SEP 19 1946

Registration District No. _____
Primary Registration District No. **5655**

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

1. PLACE OF DEATH:
(a) County Lawrence **RURAL**
(b) City or town Mt. Vernon **T.WNS.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Missouri State Sanatorium
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 904 days
In this community 904 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Buchanan
(c) City or town 618 1/2 Edmond
(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 Christopher Louis Crabtree
3. (b) If veteran, name war no
3. (c) Social Security No. 352-03-7694

4. Sex male 5. Color or race white
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 Jan 5, 1907
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>39</u>	<u>7</u>	<u>11</u>	hr. min.

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

10. Usual occupation Shoe repair

11. Industry or business Store

12. Name Robert Crabtree

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

14. Maiden name Unknown

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

16. (a) Informant E. McMichael, Record Clerk
(b) Address Mo. State San. Mt. Vernon, Mo.

17. (a) Funeral (b) Date thereof Aug 16/46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation St Joseph mo

18. (a) Signature of funeral director E. C. Sidenfaden
(b) Address St Joseph mo

19. (a) Aug 17 1946 (b) Dr. Helbrick
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. day 16th
year 1946 hour 4:20 minute A M.
21. I hereby certify that I attended the deceased from Feb. 25, 1944 to Aug. 16, 1946;
that I last saw him alive on Aug 16th, 1946;
and that death occurred on the date and hour stated above.

Immediate cause of death Pulmonary Tuberculosis Over 2 1/2 yrs
Duration

Due to _____
Due to _____

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

Major findings: 13/4
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)
(c) Means of injury _____

23. Signature P. A. Brasher M.D. (M. D. or other)
Address Mt. Vernon, Missouri Date signed 8-16-46

RECEIVED

District Health Officer No. 6,

District File Number 946-920

Date Filed SEP 5 - 1946

JAN 7 1947

SEP 11 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. K. Sidunpader

Licensed Embalmer No.

580

P. O. Address

St Joseph 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.