S. No. 2
M—8-43
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 16 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Calloway

State File No. 29999

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 726

1. PLACE OF DEATH:

(a) County: Greene

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

(c) Name of hospital or institution: SPFD. Baptist Hospital 0
(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: Three Weeks

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Oregon 75

(c) City or town: Thayer, Missouri 1
(If outside city or town limits, write "RURAL")

(d) Street No.: 0
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No) 1

If yes, name country ____

3. (a) PRINT FULL NAME: Comodore H. Crews

3. (b) If veteran, name war: World War I

3. (c) Social Security No.: UNK.

4. Sex: Male ✓

5. Color or race: White

6. (a) Single, widowed, married, divorced: Married

6. (b) Name of husband or wife: Meka Crews

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

7. Birth date of deceased: April (Month) 3, (Day) 1896 (Year)

8. AGE: Years ✓ 50 | Months 4 | Days 28 | If less than one day ____ hr. ____ min.

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

10. Usual occupation: Farmer

11. Industry or business: 0

FATHER
12. Name: Benjiman Crews
13. Birthplace: Alton (City, town, or county) Missouri (State or foreign country)

MOTHER
14. Maiden name: Eliza Jane Custer
15. Birthplace: Alton (City, town, or county) Missouri (State or foreign country)

16. (a) Informant: Meka Crews
(b) Address: Thayer, Missouri

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9-2-46 (Month) (Day) (Year)
(c) Place: burial or cremation: Thayer, Missouri

18. (a) Signature of funeral director: Herman H. Lohmeyer
(b) Address: Springfield, Missouri

19. (a) 9-2-46 (Date received local registrar) (b) W. E. Hawley M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 1 year 1946 hour 12 minute Noon M.

21. I hereby certify that I attended the deceased from 8/13 1946, to 9/1 1946, that I last saw him alive on 9/1 1946, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Tularemia —	26 days
Due to:	
Due to: 26a	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations:	
Of autopsy: Abscess in lower & in upper rt. lobe.	

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) 0

While at work? (e) Means of injury

23. Signature: Guy D. Calloway (M. D. or other) M.D.

Address: Springfield, Mo. Date signed: 9/1/46

(Licensed Embalmer's Statement on Reverse Side)

OCT 4 1946

SEP 8 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 D. L. McCann

Licensed Embalmer No. 2727

P. O. Address Springfield 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.