

FILED APR 14 1947  
Registration District No. 18

Primary Registration District No. 3040

Registrar's No. 48

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

1. PLACE OF DEATH:

(a) County Livingston

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

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

(d) Length of stay: In hospital or institution 7 days  
(Specify whether)

In this community 7 days  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Livingston

(c) City or town Rural Brook Rural Twp.  
(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 Katherine Crackenberger

3. (b) If veteran, name war .....

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March day 31  
year 1947 hour 5 minute 0 P. M.

21. I hereby certify that I attended the deceased from Mar. 24  
1947 to Mar. 31, 1947,  
that I last saw her alive on Mar. 31, 1947,  
and that death occurred on the date and hour stated above.

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

6. (b) Name of husband or wife Joseph Edward Crackenberger 6. (c) Age of husband or wife if alive deceased

7. Birth date of deceased Sept 14 1866  
(Month) (Day) (Year)

Immediate cause of death Cardiac Decompenstn Duration 3 mos

Due to Coronary sclerosis & Senility 10 yrs

Due to .....

Other conditions (include pregnancy within 3 months of death) .....

8. AGE: Years 80 Months 6 Days 17 If less than one day hr. .... min. ....

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

10. Usual occupation Housewife

Major findings: Of operations 920

Of autopsy .....

PHYSICIAN .....

Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business .....

12. Name Agustus Rosdorf

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

14. Maiden name Haydt

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

16. (a) Informant Fred Crackenberger

(b) Address Hale Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April 3-1947  
(Month) (Day) (Year)

(c) Place: burial or cremation Hale Chapel

18. (a) Signature of funeral director Frank E Slater

(b) Address Hale Mo

19. (a) April - 2 - 47 (b) Francis B. Neill  
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) .....

(b) Date of occurrence .....

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 Joseph Craven (M. D. or other) M.D.

Address Chillicothe Date signed 4/23/47

DISTRICT HEALTH OFFICE  
Cameron, Mo.

RECEIVED  
MAY 14 1910

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 *Robert E. Slater*

Licensed Embalmer No. *937*

P. O. Address *Kale 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.