

Registration District No. _____

Primary Registration District No. **3000**

Registrar's No. **72**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
1802 S. Orchard St.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **50 Years**
years, months or days

3. (a) PRINT FULL NAME **JOSEPH F. CROSS**

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

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Mrs. J. F. Cross** 6. (c) Age of husband or wife if alive **67** years

7. Birth date of deceased **January 20 1878**
(Month) (Day) (Year)

8. AGE: Years **70** Months **0** Days **28** If less than one day
hr. _____ min. _____

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

10. Usual occupation **Laborer**

11. Industry or business _____

12. Name **James F. Cross**

13. Birthplace **DK Calif.**
(City, town, or county) (State or foreign country)

14. Maiden name **Missouri Jane Phipps**

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

16. (a) Informant **Mrs. Joseph F. Cross**
(b) Address **1802 S. Orchard, Kirksville, Mo.**

17. (a) **Burial** (b) Date thereof **2-20-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Highland Park Cemet.**

18. (a) Signature of funeral director **Davis Funeral Home**

(b) Address **Kirksville, Mo.**

19. (a) **3-4-48** (b) **Kate Lambert**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Adair**
(c) City or town **Kirksville**
(If outside city or town limits, write "RURAL")
(d) Street No. **1802 S. Orchard St.**
(If rural, give location)
(e) Citizen of foreign country? **No.** (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Feb**, day **18**
year **1948** hour **6** minute **45 P.M.**

21. I hereby certify that I attended the deceased from **7 A.M.** 11
1948 to **7 P.M.** 18 1948
that I last saw him alive on **Feb. 18** 1948
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac failure** Duration _____

Due to **Acute Bronchial Asthma** 10 days

Due to **Chronic Bronchial Asthma** 15 yrs

Other conditions **General Debility** 5 yrs
(Include pregnancy within 3 months of death)

Major findings:

Of operations _____
Of autopsy **112**
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? **2**

While at work? _____ (Specify type of place) (e) Means of injury _____

23. Signature **E. Besterman** (M.D. or other) **O.**
Address **Paulsville Mo.** Date signed **2/19/48**

RECEIVED
District Health Officer No. 17
District File Number 3-48-462
Date Filed MAR 8 1948

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, ~~only~~.....

.....
working under my personal supervision.

Registered Apprentice No.

Signed

Clarence M. Billie

Licensed Embalmer No. 4375

P. O. Address

Kershville

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.