

FILED JUL 9 1948

Registration District No. **2 & 2**

Primary Registration District No. **3055**

Registrar's No. _____

1. PLACE OF DEATH:
(a) County **Lack**
(b) City or town **Balmain**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
316 W. Olive
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **8 yrs** years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Lack**
(c) City or town **Balmain** (If outside city or town limits, write "RURAL")
(d) Street No. **316 W. Olive** (If rural, give location)
(e) Citizen of foreign country? **NO** (Yes or No)
If yes, name country **None**

3. (a) **PROXIMATE FULL NAME** **Sarah Golden Crow**
3. (b) If veteran, name war **None**
3. (c) Social Security No. **None**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **June** day **20** year **1948** hour **2:40** minute **A** M.

4. Sex **Female**
5. Color or race **White**
6. (a) Single, widowed, married, divorced **Widowed**
6. (b) Name of husband or wife **John Wesley Crow**
6. (c) Age of husband or wife if alive **Deceased**
7. Birth date of deceased: **Feb 25 1870**
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from **May 1** 1948 to **June 20** 1948
that I last saw her alive on **June 19** 1948
and that death occurred on the date and hour stated above.
Immediate cause of death **Broken Hip**
Senility

8. AGE:	Years	Months	Days	If less than one day
	78	3	26	hr. min.

Duration **7 wks**

9. Birthplace: **Edgar County Missouri**
(City, town, or county) (State or foreign country)

Due to _____
Due to _____

10. Usual occupation **House keeper**

Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy _____

11. Industry or business **House work**

12. Name **Nathan Atkins**

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

14. Maiden name **Mary Elizabeth Smith**

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

16. (a) Informant **Mrs Harold Smith**
(b) Address **Balmain, Mo**

17. (a) **Burial** (b) Date thereof **June 23 1948**
(Burial, cremation, or reposal) (Month) (Day) (Year)

(c) Place: burial or cremation **Harold Cemetery**

18. (a) Signature of funeral director **Erwin B. Blue**
(b) Address **Balmain, Mo**

19. (a) **July 2 1948** (b) **Ralph Gardner**
(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 _____
(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) (Means of injury)

23. Signature **R. B. Bridges** (M. D. or other)
Address **Balmain, Mo**

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

PHYSICIAN
Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 7,

District File Number 6-48-760

Date Filed 7-8-08

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 Chy Jester

Licensed Embalmer No. 4154

P. O. Address Bolivar, 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.

Registration District No. 282

Primary Registration District No. 2055

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Polk
(b) City or town Bolivar
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community _____ years, months or days

3. (a) PRINT FULL NAME Sarah G Crow

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced wid

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jul 25 (Month) (Day) (Year)

8. AGE: Years 78 Months _____ Days _____ If less than one day _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) (State or foreign country) No

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER

12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

13. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
(c) City or town _____ (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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ Day _____ Year _____ hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____; that I last saw him/her alive on _____, 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Duration _____

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings: 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) accidental fall

(b) Date of occurrence May 1982

(c) Where did injury occur? Bolivar Polk Mo (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? Home

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

23. Signature _____ (M. D. or other)

Address _____ Date signed _____

SUPPLEMENTARY

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

S - 20395