

MISSOURI DIVISION OF HEALTH  
STANDARD CERTIFICATE OF DEATHState File No. **22024**

FILED JUL 21 1948

Registration District No. ....

Primary Registration District No. **3000**Registrar's No. **190**

## 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:  
**Grim-Smith Memorial Hospital**  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution. **2da. 4hrs. 33min.**  
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Frank P. Crim**

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 **Kate Crim** 6. (c) Age of husband or wife if alive ..... years  
7. Birth date of deceased **April 17 1868**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
<b>80</b>		<b>3</b>	<b>8</b>	<b>4</b> hr. <b>23</b> min.

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

10. Usual occupation .....

11. Industry or business .....

12. Name **Enoch Crim**13. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)14. Maiden name **Nancy Feacher**15. Birthplace **Tenn.**  
(City, town, or county) (State or foreign country)16. (a) Informant **Mrs. Kate Crim**(b) Address **Lancaster Mo.**17. (a) **Burial** (b) Date thereof **7-10-48**  
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation **Aspi Memorial**18. (a) Signature of funeral director **Dwight J. Jenson**(b) Address **Lancaster Mo.**19. (a) **7-17-48** (b) **Kate Lambert**  
(Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Schuyler**  
(c) City or town **Lancaster**  
(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 **July** day **8**  
year **1948** hour **7:37** minute **P.M.**21. I hereby certify that I attended the deceased from **July 6**  
19**48**, to **July 8**, 19**48**  
that I last saw him alive on **July 8**, 19**48**  
and that death occurred on the date and hour stated above.Immediate cause of death **GANGRENE OF**  
**RIGHT LEG AND ANEMIA**  
Duration **3 WKS.**Due to **THROMBOSIS OR EMBOLISM** **2 Mos.**  
**AND POOR NURSING CARE**Due to **VALVULAR HEART DISEASE** **Sev. Yrs.**Other conditions .....  
(Include pregnancy within 3 months of death)Major findings:  
Of operations .....

Of autopsy .....

## PHYSICIAN

Underline the cause of 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)

While at work? ..... (Specify type of place)

23. Signature **George E. Grim** (M. D. or other) **MD**Address **KIRKSVILLE, MO.** Date signed **7-13-48**

DEC 7 9 1950

RECEIVED

District Health Officer No. 10

District File Number 7-48-176

Date Filed JUL 20 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, or by.....

..... Registered Apprentice No. ....  
working under my personal supervision.

Signed *Purcell Fenton*

Licensed Embalmer No. *3705*

P. O. Address *Lancaster, Pa.*

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. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair  
(b) City or town Kirkville  
(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 Frank P. Crum

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

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

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

7. Birth date of deceased April 17 1902  
(Month) (Day) (Year)

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

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

10. Usual occupation Merchant (retired)

11. Industry or business

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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) 7-30-48 (b) Kate Lambert  
(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 Aug Year 1948 hour 11 minute 00 M.

21. I hereby certify that I attended the deceased from 1948 to 1948 that I last saw him alive on and that death occurred on the date and hour stated above. Immediate cause of death stroke Duration

Due to

Due to

Other conditions (Includes 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)  
(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) (e) Means of injury

23. Signature (M. D. or other)

Address Date signed

**SUPPLEMENTARY**

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

MOTHER FATHER

5-22024