

FILED AUG 2 1948

Registration District No. **209**

Primary Registration District No. **3043**

Registrar's No. **233**

1. PLACE OF DEATH:
 (a) County **Marion**
 (b) City or town **Hannibal**
(If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
1708 Wardlow St
(If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution **1**
(Specify whether)

2. USUAL RESIDENCE OF DECEASED:
 (a) State **MO** (b) County **Marion**⁶⁴
 (c) City or town **Hannibal**⁴
(If outside city or town limits, write "RURAL")
 (d) Street No. **1708 Wardlow St**
(If rural, give location)
 (e) Citizen of foreign country? _____ (Yes or No)
 If yes, name country _____

3. (a) PRINT FULL NAME **Frank Cromes**
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____
 4. Sex **male** 5. Color or race **negro**
 6. (a) Single, widowed, married **wid**
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased **9 25 1876**
(Month) (Day) (Year)

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month **7** day **14**
 year **1948** hour **12** minute **10 AM**
 21. I hereby certify that I attended the deceased from **May 6**, 19**48** to **July 14**, 19**48**
 that I last saw him alive on **7/14/48**
 and that death occurred on the date and hour stated above.

8. AGE:

Years	Months	Days	If less than one day
72	9	19	hr. _____ min. _____

Immediate cause of death _____
Cerebral apoplexy
 Due to _____
 Due to _____
 Other conditions _____
(Include pregnancy within 3 months of death)
G-3W

9. Birthplace **Hannibal MO**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**
11. Industry or business
12. Name **Toby Cromes**
13. Birthplace **Hannibal MO**
(City, town, or county) (State or foreign country)
14. Maiden name **Sarah**
15. Birthplace **MO**
(City, town, or county) (State or foreign country)

PHYSICIAN
 Major findings:
 Of operations _____
 Of autopsy _____
 Underline the cause to which death should be charged statistically.

16. (a) Informant **Netha Webster**
 (b) Address **1708 Wardlow St**
17. (a) Burial (b) Date thereof **7-16-48**
(Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation **Robinson**
18. (a) Signature of funeral director **Geo E. Roberts**
 (b) Address **Hannibal MO**
19. (a) 7-24-48 (b) **W E M Luckey**
(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?
 While at work? _____ (Specify type of place)
 (c) Means of injury _____
23. Signature **W E M Luckey** (M. D. or other) **W E M**
 Address **Hannibal MO** Date signed **7/14/48**

MOTHER, FATHER

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

Geo E Roberts

Licensed Embalmer No. *2113*

P. O. Address *Hannibal Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 449
Registrar's No. 233

Registration District No. 209

Primary Registration District No. 3043

1. PLACE OF DEATH:

(a) County marion
(b) City or town Hannibal
(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 _____ (Specify whether _____)
years, months or days

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 _____

3. (a) PRINT FULL NAME Frank Cromer

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

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

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

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

8. AGE: Years 72 Months _____ Days _____ If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

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

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month _____ year 1944 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) _____

(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

MOTHER FATHER

5-2355.2

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