

FILED AUG 5 1948

State File No. 142

Registration District No. \_\_\_\_\_

Primary Registration District No. 3058

Registrar's No. 147

1. PLACE OF DEATH:

(a) County St. Charles  
(b) City or town St. Charles  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: St. Joseph Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 6 1/2 hours  
(Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_  
years, months or days

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. 412 W. Buchanan  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Bonnie Crow

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

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Emory Crow 6. (c) Age of husband or wife if alive 43 years  
7. Birth date of deceased June 23 1904  
(Month) (Day) (Year)

8. AGE: Years 44 Months 0 Days 26 If less than one day  
hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name Dave E. Barclay

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

14. Maiden name Amanda Jane Dabney

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

16. (a) Informant Charlie Crow

(b) Address Kirksville, Mo

17. (a) Removal (b) Date thereof 7/19/48  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kirksville, Mo

18. (a) Signature of funeral director H. O. Dallmeyer & Sons

(b) Address 800 N. 2nd St. Charles, Mo.

19. (a) July 26 1948 Bonnie Crow  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19  
year 1948 hour 3:22 minute A. M.

21. I hereby certify that I attended the deceased from 7/22/48 to \_\_\_\_\_, 19\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_;  
that I last saw him alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Automobile accident Duration \_\_\_\_\_

Due to bodily injuries sustained in accident.

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: 1. Of operations \_\_\_\_\_

Of autopsy None

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) Accident 130

(b) Date of occurrence July 19th, 1948

(c) Where did injury occur? Hwy. 40-St. Chas. Cty.  
(City or town) (County) (State)

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

While at work? \_\_\_\_\_ (Specify type of place) (e) Means of injury Auto Accident

Signature Marie Murchison (Physician)

Address Westport, Mo Date signed 7-22-48

RECEIVED  
District Health Officer No. 9,  
District File Number  
Date Filed AUG 2 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 *Joseph E. Lindseth*  
Licensed Embalmer No. *4189*  
P. O. Address *St. Charles 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.