

FILED NOV 29 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

36156

State File No. \_\_\_\_\_

Registration District No. 128

Primary Registration District No. 2000

Registrar's No. 1024

1. PLACE OF DEATH:

(a) County Greene  
 (b) City or town Springfield  
(If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: St Johns Hospital  
(If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution \_\_\_\_\_  
(Specify whether  
 In this community 72 Years  
years, months or days)

3. (a) PRINT FULL NAME Martin V. Crain

3. (b) If veteran, name war None 3. (c) Social Security No. None

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

6. (b) Name of husband or wife Louella Crain 6. (c) Age of husband or wife if alive dec. years

7. Birth date of deceased May 18, 1876  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<u>72</u>	<u>6</u>	<u>4</u>	hr. _____ min.

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

10. Usual occupation Retired Policeman

11. Industry or business Policeman

MOTHER FATHER { 12. Name William Crain  
 { 13. Birthplace Mo.  
(City, town, or county) (State or foreign country)  
 { 14. Maiden name Louisa Wommack  
 { 15. Birthplace Mo.  
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Carl Potter,  
 (b) Address Springfield Mo.  
 17. (a) Burial (b) Date thereof 11-24-1948  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Greenlawn Cem.  
 18. (a) Signature of funeral director W.K. Klingner & Co.,  
 (b) Address Springfield Mo.

19. (a) 11-23-48 (b) W.F. Haubling  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Greene  
 (c) City or town Springfield  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 1015 N. Rogers  
(If rural, give location)  
 (e) Citizen of foreign country? No. (Yes or No)  
 If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November 22,  
 year 1948 hour 10: minute 30 A. M.

21. I hereby certify that I attended the deceased from Nov 15, 1948 to Nov 22, 1948  
 that I last saw him alive on Nov 22, 1948  
 and that death occurred on the date and hour stated above.

Immediate cause of death Acute Coronary Occlusion

Due to Generalized Atherosclerosis

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

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

Major findings: Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration

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 T.D. Duncan (M. D. or other) MD  
 Address Springfield Mo. Date signed 11/23/48

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

**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.....

*Max Rhodes*

Licensed Embalmer No.....

*4071*

P. O. Address.....

*Springfield*

**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.