

FILED MAR 11 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No.

5391

BIRTH NO. _____		REG. DIST. NO. <u>172</u>		PRIMARY REG. DIST. NO. <u>5671</u>		Registrar's No. <u>12</u>	
1. PLACE OF DEATH a. COUNTY <u>Lafayette</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before a. STATE <u>Missouri</u> b. COUNTY <u>Lafayette</u> admission) <u>24</u>			
b. CITY OR TOWN <u>Corder, Mo. Dover Twp.</u>		c. LENGTH OF STAY (in this place) <u>3 Years</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Corder, rural Dover Twp.</u>			
d. FULL NAME OF HOSPITAL OR INSTITUTION. <u>1</u>				d. STREET ADDRESS (If rural, give location) <u>R.F.D. 1</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Mack</u>			b. (Middle) <u>-</u>		c. (Last) <u>Crick</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 2 1949</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 27/1865</u>		9. AGE (In years last birthday) <u>83</u>	IF UNDER 1 YEAR Months <u>3</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Oil Town, Pennsylvania/</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>James R. Crick</u>		13b. MOTHER'S MAIDEN NAME <u>Rachel Rankin</u>		14. NAME OF HUSBAND OR WIFE <u>Mary F. Earp/Crick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>No.</u>		17. INFORMANT'S SIGNATURE OR NAME - ADDRESS <u>Jake Crick - Corder, Mo. #1</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Quinlan fibrillation sente</u> ANTECEDENT CAUSES. <u>Myocardial infarction</u> DUE TO (b) <u>Thrombus sente, common iliofemoral artery 1 day</u> DUE TO (c) <u></u> II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>4331</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR			
22. I hereby certify that I attended the deceased from <u>25 Feb., 1949, to 2 March, 1949</u> , that I last saw the deceased alive on <u>2 March, 1949</u> , and that death occurred at <u>10:30 A.M.</u> , from the causes and on the date stated above.							
23a. SIGNATURE (Degree or title) <u>Douglas Kelling M.D.</u>				23b. ADDRESS <u>Waverly, Mo</u>		23c. DATE SIGNED <u>3-2-49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>3/4/49</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Matta Bend Cemetery</u>		24d. LOCATION (City, town, or county) (State) <u>Matta Bend, Mo</u>		
DATE REC'D BY LOCAL REG. <u>March 2-49</u>		REGISTRAR'S SIGNATURE <u>Clayton N. Landrum</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. Lealie Surrency</u>		ADDRESS <u>Waverly, Mo</u>	

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 3-10-49

MS OCT 4 1961

MAR 14 1949

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 _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed J. Leslie Surgeny

Licensed Embalmer No. 3235

P. O. Address Marshall, W.

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.