

FILED NOV 25 1949

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **36291**

BIRTH NO. _____		REG. DIST. NO. <u>32</u>		PRIMARY REG. DIST. NO. <u>5112A</u> Registrar's No. <u>74</u>	
1. PLACE OF DEATH a. COUNTY <u>Bollinger</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Mo</u> b. COUNTY <u>Bollinger</u>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural / Scopus</u>		c. LENGTH OF STAY (In this place) <u>Entire life</u>	c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Rural / Scopus</u>		d. STREET ADDRESS (If rural, give location) <u>Sedgewickville Rural 4 miles SW Vile 1</u>
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>4 miles S.W. Sedgewickville</u>			d. STREET ADDRESS (If rural, give location) <u>Rural 4 miles SW Vile 1</u>		
3. NAME OF DECEASED (Type or Print) a. (First) <u>Barbra</u>			b. (Middle) <u>Crites</u>	c. (Last) <u>Crites</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Oct 27-1949</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept 13, 1869</u>	9. AGE (In years last birthday) <u>80</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>15</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeping</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Bollinger Co. Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13a. FATHER'S NAME <u>Thomas Seabaugh</u>		13b. MOTHER'S MAIDEN NAME <u>Sarah Robinson</u>		14. NAME OF HUSBAND OR WIFE <u>Jacob Crites</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>✓</u>	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <u>J.D. Crites Sedgewickville</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, asphyxia, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Gastro-enteritis</u> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 5711				INTERVAL BETWEEN ONSET AND DEATH
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) (Minute)	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>Oct 17, 1949</u> , to <u>Oct 27, 1949</u> , that I last saw the deceased alive on <u>Oct 24, 1949</u> , and that death occurred at <u>8 A</u> m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) <u>Edw. Crites</u>		23b. ADDRESS <u>M.L.O. Sedgewickville, Mo</u>		23c. DATE SIGNED <u>11/13/49</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	24b. DATE <u>Oct 29, 1949</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Sargents Chapel</u>	24d. LOCATION (City, town, or county) (State) <u>Near Sedgewickville Mo</u>		
DATE REC'D BY LOCAL REG. <u>Nov. 19, 1949</u>	REGISTRAR'S SIGNATURE <u>William Van Amburgh</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>25 S. P. Krauss</u>	ADDRESS <u>Jackson, Mo</u>		

(Licensed Embalmer's Statement on Reverse Side)

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

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RECEIVED 11-23-49
District Health Officer No. 4
File Number 1149-1536
Date Filed _____

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 _____

working under my personal supervision.

Student Embalmer No. _____

Signed Gene C. Crockett

Signed _____
Student Embalmer

Licensed Embalmer No. 4327

P. O. Address Jackson, Mo

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.