

FILED MAY 26 1952

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

15576

State File No.

BIRTH NO. 727492 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 3006 Registrar's No. 134

05
WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH a. COUNTY BOONE | | 2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE MISSOURI b. COUNTY BOONE | |
| b. CITY (If outside corporate limits, write RURAL and give township) COLUMBIA | | c. CITY (If outside corporate limits, write RURAL and give township) COLUMBIA | |
| c. LENGTH OF STAY (In this place) 17 days | | d. STREET ADDRESS (If rural, give location) SMARR CT | |
| d. FULL NAME OF HOSPITAL OR INSTITUTION BOONE COUNTY HOSPL | | | |

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|--|-------------------------------|--|---|--|---|
| 3. NAME OF DECEASED (Type or Print) a. (First) GARLAND b. (Middle) FREDERICK c. (Last) CRANE | | | 4. DATE OF DEATH (Month) (Day) (Year) MAY 17 1952 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) BABY | 8. DATE OF BIRTH MAY 1st 1952 | 9. AGE (In years last birthday) X | IF UNDER 1 YEAR: MONTHS X DAYS 17 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BABY | | 10b. KIND OF BUSINESS OR INDUSTRY BABY | | 11. BIRTHPLACE (State or foreign country) BOONE COUNTY HOSPITAL | |
| | | | | 12. CITIZEN OF WHAT COUNTRY? USA | |

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|--|--|---|--|---|--|
| 13a. FATHER'S NAME JAMES WALTER CRANE | | 13b. MOTHER'S MAIDEN NAME MARY PAPIN | | 14. NAME OF HUSBAND OR WIFE BABY | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or date of service) XX | | 16. SOCIAL SECURITY NO. XX | | 17. INFORMANT'S SIGNATURE OR NAME JAMES WALTER CRANE ADDRESS COLUMBIA | |

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|--|--|--|-----------------------|--|--|---|--|--|
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) CONGENITAL ENGERGATION OF THE INTESTINAL TRACT | | | MEDICAL CERTIFICATION | | | INTERVAL BETWEEN ONSET AND DEATH 17 days | | |
| I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) | | | DUPLICATE TO (b) | | | | | |
| *This does not mean the mode of dying, such as heart failure, ashenia, etc. It means the disease, injury, or complication which caused death. | | | DUPLICATE TO (c) | | | | | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ASPIRATION OF FORMULA | | | | | | | | |

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|---|--|---|--|---|--|--|--|
| 19a. DATE OF OPERATION 5/1/52 | | 19b. MAJOR FINDINGS OF OPERATION COLON AND TERMINAL ILLIUM RESECTED. END TO END ANASTOMOSIS OF ILLIUM TO RECTUM. | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input 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) | | 21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? 5604 | | | |

22. I hereby certify that I attended the deceased from 5/1, 1952, to 5/17, 1952, that I last saw the deceased alive on 5/17, 1952, and that death occurred at 12:30 P. m., from the causes and on the date stated above.

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|--|--|--|--|--|--|
| 23a. SIGNATURE Edward L. Washington MD. (Degree or title) | | 23b. ADDRESS 909 University, Columbia Mo. | | 23c. DATE SIGNED 5/17/52 | |
| 24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 24b. DATE MAY 19-52 | | 24c. NAME OF CEMETERY OR CREMATORY NASHVILLE | |
| | | | | 24d. LOCATION (City, town, or county) (State) BOONE COUNTY MO | |

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|---|--|---|--|---|--|
| DATE REC'D BY LOCAL REG. May 19 1952 | | REGISTRAR'S SIGNATURE Mrs R E Palmer | | 25. SANITARY DIRECTOR'S SIGNATURE [Signature] ADDRESS Columbia Mo | |
|---|--|---|--|---|--|

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate ^{was} ~~was~~ embalmed by me, or by _____

Student Embalmer No. _____

working under my personal supervision.

Student
Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

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.