

FILED SEP 7 1955

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

26710

State File No. ....

BIRTH NO. \_\_\_\_\_ REG. DIST. NO. 155 PRIMARY REG. DIST. NO. 3127 Registrar's No. 124

1. PLACE OF DEATH a. COUNTY <b>Jasper</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Missouri</b> b. COUNTY <b>Jasper</b>	
b. CITY (If outside corporate limits, write RURAL and give OR TOWN <b>Webb City</b> )	c. LENGTH OF STAY (in this place) township) <b>19 Days</b>	c. CITY OR TOWN <b>Oronogo</b>	d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION <b>Jane Chinn Hospital</b>		STREET ADDRESS (If rural, give location) <b>0490</b>	

3. NAME OF DECEASED (Type or Print)	a. (First) <b>John</b>	b. (Middle) <b>L.</b>	c. (Last) <b>Crosby</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>Aug. 30, 1955</b>
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5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>July 1, 1859</b>	9. AGE (In years last birthday) <b>96</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>29</b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brick mason</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and State or Foreign Country) <b>Galesburg, Ill.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
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13a. FATHER'S NAME <b>John Thomas Crosby</b>	13b. MOTHER'S MAIDEN NAME	14. NAME OF HUSBAND OR WIFE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE OR NAME ADDRESS <b>M.E. Crosby 2350 Utica Joplin, Mo.</b>
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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, asthenia, etc. It means the disease, injury, or complication which caused death.	1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Congestive Circulatory Failure</b>		INTERVAL BETWEEN ONSET AND DEATH. <b>1 day</b>	
	ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) <b>gangrene of rt foot</b>			<b>5 days</b>
	DUE TO (c) <b>arteriosclerosis</b>			<b>Unknown</b>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <b>4501</b>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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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)
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 8-12, 1955, to 8-30, 1955, that I last saw the deceased alive on 8-30, 1955, and that death occurred at 1:45Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) <b>D. O. Gregory</b>	23b. ADDRESS <b>Webb City, Mo.</b>	23c. DATE SIGNED <b>8-31-55</b>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	24b. DATE <b>Sept 2-1955</b>	24c. NAME OF CEMETERY OR CREMATORY <b>Weaver Cemetery</b>	24d. LOCATION (City, town, or county) (State) <b>N. of Oronogo, Mo.</b>
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DATE REC'D BY LOCAL REG. <b>9-2-55</b>	REGISTRAR'S SIGNATURE <b>Mrs. Madeline Switzer</b>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Johnston-Arnice-Simpson, Webb City, Mo. Montuany</b>
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(Licensed Embalmer's Statement on Reverse Side)

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

300  
48

492

Courtesy File Number ST 6-622  
Date Filed SEP 5 - 1955

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 \_\_\_\_\_  
Signature of Student Embalmer

Signed Harvey E. Arnee  
Licensed Embalmer No. 446

P. O. Address Webb City

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.