

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

32441

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

BIRTH NO. _____		REG. DIST. NO. <u>53</u>		PRIMARY REG. DIST. NO. <u>3010</u>		Registrar's No. <u>424</u>	
1. PLACE OF DEATH a. COUNTY <u>Cape Girardeau</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <u>Missouri</u> b. COUNTY <u>Cape Gir</u>			
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Cape Girardeau</u>		c. LENGTH OF STAY (in this place) <u>25 yr</u>		c. CITY OR TOWN <u>Randles</u>		d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>Southeast Hospital</u>				STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED (Type or Print) a. (First) <u>Ora</u>			b. (Middle) _____		c. (Last) <u>Crader</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Nov 21 1955</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>Sept 22 1891</u>		9. AGE (In years last birthday) <u>64</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>9</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>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (City and State or Foreign Country) <u>Marble Hill Mo.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13a. FATHER'S NAME <u>A.T Crader</u>			13b. MOTHER'S MAIDEN NAME <u>Unknown</u>		14. NAME OF HUSBAND OR WIFE <u>None</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT'S SIGNATURE OR NAME <u>Mrs. Louis Smith</u> ADDRESS <u>Marble Hill Mo.</u>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  <i>*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.</i>	MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH <u>about 1 week</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Subdural hemorrhage</u>						
	ANTECEDENT CAUSES <u>Subarachnoid</u>						
	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 <u>Bilateral confluent pneumonia</u>						
	Conditions contributing to the death but not related to the disease or condition causing death.						
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____				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.) <u>street</u>		21c. (CITY, TOWN, OR TOWNSHIP) <u>Delta, Scott, Mo.</u> (COUNTY) _____ (STATE) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>Oct. 23, 1955 10 p.m.</u>		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Hit by automobile</u>			
22. I hereby certify that I attended the deceased from <u>10-23-</u> , 19 <u>55</u> , to <u>11-2-</u> , 19 <u>55</u> that I last saw the deceased alive on <u>11-1-</u> , 19 <u>55</u> , and that death occurred at <u>12:30 A</u> m., from the causes and on the date stated above.							
23a. SIGNATURE <u> Gordon M. Munnally, M.D.</u> (Degree or title) _____				23b. ADDRESS <u>937 Broadway, Cape Girardeau, Mo.</u>		23c. DATE SIGNED <u>11-4-55</u>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24b. DATE <u>Nov 6 1955</u>	24c. NAME OF CEMETERY OR CREMATORY <u>Hahn's Chapel</u>		24d. LOCATION (City, town, or county) (State) <u>Marble Hill Mo.</u>		
DATE REC'D BY LOCAL REG. <u>11-7-55</u>		REGISTRAR'S SIGNATURE <u>W. P. Summers</u> <u>44-0</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Burke &amp; House - Cape Gir Mo.</u> ADDRESS _____			

(Licensed Embalmer's Statement on Reverse Side)

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

256. 07. 114

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 NEIL H. GROSSHEIDER, Student Embalmer No. 52 working under my personal supervision..

Student Neil H. Grossheider Signed W. H. Estes  
Signature of Student Embalmer

Licensed Embalmer No. 356  
P. O. Address Cape Si

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.