

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

58-038853

STATE FILE NUMBER
69

FILED DEC 9 1958

Registration District No. 032 Primary Registration District No. Registrar's No.

300
1-57

1. PLACE OF DEATH a. COUNTY <i>Bollinger</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Mo</i> b. COUNTY <i>Bollinger</i>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <i>Scopus Township</i>		Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>	c. CITY OR TOWN <i>Rural</i> 0090 Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <i>At home</i>		Length of stay in 1b	d. STREET ADDRESS (If outside, give location) <i>4mi South Sedgewickville Mo</i> Reside on Farm Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First Middle Last <i>Thomas Daniel Crites</i>			4. DATE OF DEATH Month Day Year <i>Nov 21, 1958</i>	
--	--	--	--	--

5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 22, 1894</i>	9. AGE (In years) 1st birthday <i>63</i>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
--------------------	------------------------------	---	---	---	--------------------------------	--------------------------------

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>	11. BIRTHPLACE (City and state or country) <i>Friedheim, Mo</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
--	---	--	---

13a. FATHER'S NAME <i>Jacob Crites</i>	13b. MOTHER'S MAIDEN NAME <i>Barbara Seabough</i>	14. NAME OF HUSBAND OR WIFE <i>Ostie Hanners Crites</i>
---	--	--

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>None</i>	17. INFORMANT Address <i>Ostie Crites Sedgewickville, Mo</i>
--	--	---

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive Myocarditis</i>		INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to above cause (a), stating the underlying cause lost. } DUE TO (b)		
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
20c. TIME OF INJURY Hour Month, Day, Year p.m.	

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE
--	--	---

21. I attended the deceased from *Jan 1st 1908* to *Nov 21st 58* and last saw ^{her} him alive on *Nov 19th 1958*
Death occurred at *9 p.m.* on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title) <i>Edgar Crites M.D.</i>	22b. ADDRESS <i>Sedgewickville Mo</i>	22c. DATE SIGNED <i>11/27/58</i>
--	--	-------------------------------------

23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>Nov 23, 1958</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Sedgewickville, Mo</i>	23d. LOCATION (City, town, or county) (State) <i>Sedgewickville Mo</i>
--	----------------------------------	---	---

24. FUNERAL DIRECTOR ADDRESS <i>H. C. Coughlin, Jackson, Mo</i>	25. DATE RECD. BY LOCAL REG. <i>12-1-58</i>	26. REGISTRAR'S SIGNATURE <i>Mrs Buford Crader</i>
--	--	---

(Licensed Embalmer's Statement on Reverse Side)

All diseases in Part I must be causally related.

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

DEC 29 1958

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 *E. C. Cunniff*

Licensed Embalmer No. *4397*

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.