Health, & Welfare Public Service

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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-002633
STATE FILE NUMBER

FILED JAN 21 1959 Registration District No. 316 Primary Registration District No. 6074 Registrar's No. 6

1. PLACE OF DEATH a. COUNTY St, Francois	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Francois
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Randolph — Inside Limits Yes ☒ No ☐	c. CITY OR TOWN Leadwood, 0940 — Inside Limits Yes ☒ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in 1b	d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED (Type or print) First: William	Middle: Henry	Last: Crump	4. DATE OF DEATH Month Day Year: Jan. 10, 1959
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ 2 DIVORCED ☐	8. DATE OF BIRTH: Aug, 19, 1879
9. AGE (In years last birthday): 79	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): Well Driller	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (City and state or country): Bonne Terre, Mo,	12. CITIZEN OF WHAT COUNTRY? U,S.A
13a. FATHER'S NAME: Oliver Crump	13b. MOTHER'S MAIDEN NAME: Rachel Pirtle	14. NAME OF HUSBAND OR WIFE: Emma Crump	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: None	17. INFORMANT: Berniece Helms Address: Wortham, Missouri	

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Bronchial pneumonia	5 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Cardiac decompensation	10 days
DUE TO (c)	arteriosclerotic cardiovascular disease	not known

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) 4221

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	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 Dec 23 1958 to Jan 10 1959 and last saw ~~her~~ him alive on Jan 9 1959
Death occurred at 11 PM on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE John W Hunt Jr (Degree or title) MD	22b. ADDRESS Leadwood Mo	22c. DATE SIGNED 1/19/59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Jan, 13, 1959	23c. NAME OF CEMETERY OR CREMATORY: Woodlawn	23d. LOCATION (City, town, or county) (State): Leadington Mo,
24. FUNERAL DIRECTOR: Bert L Boyer	ADDRESS: Leadwood Mo	25. DATE RECD. BY LOCAL REG.: Jan. 12, 1959	26. REGISTRAR'S SIGNATURE: Esther Rudolff

(Licensed Embalmer's Statement on Reverse Side)

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be causally related.

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 .....

Licensed Embalmer No. 3445

P. O. Address Leadwood 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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.

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