Health, Welfare Public Service

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1-57

THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-009197
STATE FILE NUMBER

FILED APR 7 1959 Registration District No. 138 Primary Registration District No. Registrar's No. 13

1. PLACE OF DEATH
a. COUNTY Hickory
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Preston — Inside Limits Yes ☑ No ☐
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION — Length of stay in Ib 14 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo. b. COUNTY Hickory
c. CITY OR TOWN Preston 0430 — Inside Limits Yes ☑ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print) First: Lucinda Middle: Frances Last: Crane
4. DATE OF DEATH Month Day Year: 3-24-1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 12-1878
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR Months: 0 Days: 12 — IF UNDER 24 HRS. Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (City and state or country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.
13a. FATHER'S NAME: William S. Moore
13b. MOTHER'S MAIDEN NAME: Jane A. Tyler
14. NAME OF HUSBAND OR WIFE: John Henry Crane
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Ray Crane — Address: Alexandria, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Apoplexy of Brain — INTERVAL BETWEEN ONSET AND DEATH: 12 Hours
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b) Arterial Sclerosis — years
DUE TO (c) 334X
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 ☐ 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 Oct 1957, to March 24, 1959 and last saw her/him alive on March 24, 1959
Death occurred at m on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): J. E. Briggs, D.O.
22b. ADDRESS: Weatland, Mo
22c. DATE SIGNED: 3-30-59

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 3-25-1959
23c. NAME OF CEMETERY OR CREMATORY: Mocks Creek Cem.
23d. LOCATION (City, town, or county) (State): Camden Co. Mo

24. FUNERAL DIRECTOR: Allen W. Vaughan — ADDRESS: Urbana, Mo
25. DATE RECD. BY LOCAL REG.: 3-31-1959
26. REGISTRAR'S SIGNATURE: May Johnson

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

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 Allen W. Vaughan

Licensed Embalmer No. 4156

P. O. Address Urbana, 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.