

OCT 25 1938

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32728
Do not use this space.

1. PLACE OF DEATH
 (a) County Warren Registration District No. 677 542
 (b) Township Jackson Primary Registration District No. 5731 Registered No. 121
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs. Della May Krone
 (a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jack Krone

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 26, 1877

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, hrs. or min.
<u>61</u>	<u>4</u>	<u>24</u>		

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. At Home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

12. BIRTHPLACE (CITY OR TOWN) Marion Co
 (STATE OR COUNTRY) Missouri

FATHER
 13. NAME Thomas Bowman
 14. BIRTHPLACE (CITY OR TOWN) Marion Co
 (STATE OR COUNTRY) Mo.

MOTHER
 15. MAIDEN NAME Elizabeth Carnes
 16. BIRTHPLACE (CITY OR TOWN) Marion Co
 (STATE OR COUNTRY) Mo.

17. INFORMANT Jack Krone
 (ADDRESS) Vienna Mo. R.F.D. No. 1

18. BURIAL, CREMATION, OR REMOVAL
 PLACE Krone Cemetery DATE 9/22 1938

19. FUNERAL DIRECTOR (NAME) Mrs. Harry McCaw
 (ADDRESS) Roca

20. FILED _____, 19 _____
 Local Registrar. 493

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/20, 1938

22. I HEREBY CERTIFY, That I attended deceased from 9-19-1938 to 9-20-1938
 I last saw him alive on 9-19-1938. Death is said to have occurred on the date stated above, at 6 a. m.
 The principal cause of death and related causes of importance were as follows:
Endocarditis!

Date of onset about 1 year

Other contributory causes of importance:
Rheumatic Inflammation
Chronic Arthritis
For years

Name of operation _____ Date of _____
 What test confirmed diagnosis? Symptoms Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19 _____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
 Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) Dr. R. J. Turrett, M. D.
Belle, Mo.
 (Address) _____

92B

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,

R. E. McCaw

or by _____

Registered Apprentice No. _____, working under my personal supervision

Signed *R. E. McCaw*

Licensed Embalmer No. *393*

P. O. Address *Rice*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32728

Do not use this space.

PLACE OF DEATH

- (a) County Marion Registration District No. _____
(b) Township _____ Primary Registration District No. _____ Registered No. _____
(c) City _____ (d) Street No. _____ St. _____
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Della M. Krane

- (a) Residence, No. _____ St. _____
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>F</u>	4. COLOR OR RACE <u>W</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>m</u>		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR)				
7. AGE	YEARS <u>61</u>	MONTHS <u>4</u>	DAYS <u>24</u>	IF LESS than 1 day, hrs. or min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.			
	9. Industry or business in which work was done, as saw mill, bank, etc.			
	10. Date deceased last worked at this occupation (month and year)			
11. Total time (years) spent in this occupation				
12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)				
FATHER	13. NAME			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
MOTHER	15. MAIDEN NAME			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)			
17. INFORMANT (ADDRESS)				
18. BURIAL, CREMATION, OR REMOVAL				
PLACE _____ DATE _____ 19__				
19. FUNERAL DIRECTOR (ADDRESS)				
20. FILED _____ 19__				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Sept 20 1938

22. I HEREBY CERTIFY, That I attended deceased from _____, 19____, to _____, 19____.

I last saw h _____ alive on _____, 19____. Death is said to have occurred on the date stated above, at _____ m.

The principal cause of death and related causes of importance were as follows:

Endocarditis
Acute endocarditis
Rheumatic Deformity
Arteriosclerosis
Date of onset 9/1/38

Name of operation _____ Date of _____
What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? _____ Date of injury _____, 19____
Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____
Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____
If so, specify _____
(Signed) N. R. Ferrell _____, M. D.
(Address) Belle _____

Local Registrar.

FILL IN ANSWERS TO ALL SPACES
CHECKED IN RED PENCIL.

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

32728

Do not use this space.

1. PLACE OF DEATH

(a) County Marion Registration District No. 342
 (b) Township Jepson Primary Registration District No. 673 Registered No. 121 (34)
 (c) City..... (d) Street No..... (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred, yrs. mos. ds. (f) How long in U.S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Mrs Della Mary Krone

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX 7 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Jack Krone
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Apr 26 - 1877
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 61 4 24
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. at Home
 9. Industry or business in which work was done, as saw mill, bank, etc.
 10. Date deceased last worked at this occupation (month and year)
 11. Total time (years) spent in this occupation

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 9/20 1938
 22. I HEREBY CERTIFY, That I attended deceased from 9-19 1938 to 9-20 1938
 I last saw her alive on 9-19 1938. Death is said to have occurred on the date stated above, at 6 a.m.
 The principal cause of death and related causes of importance were as follows:

Endo Carditis
 Date of onset Sept 1938
 Other contributory causes of importance:
Pneumatic Deformities
Chr Arthritis
none
 Name of operation
 What test confirmed diagnosis? symptomatic Date of _____ Was there an autopsy? no

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo
 FATHER 13. NAME Thomas Bowman
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo
 MOTHER 15. MAIDEN NAME Elizabeth Carnes
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Marion Mo
 17. INFORMANT (ADDRESS) Jack Krone
Vienna Mo R.F.D.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Krone Cem DATE 9/22 1938
 19. FUNERAL DIRECTOR (ADDRESS) Mrs Harris McCreary
Kolloy
 20. FILED 11/15 1938 Monica M. Gade Local Registrar.

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____ 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place.
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased? no
 If so, specify _____
 (Signed) W. R. Ferrell M. D.
 (Address) Belle Mo

REGISTRARS SHALL NOT RECEIVE A FEE FOR CERTIFICATES UNTIL THEY ARE COMPLETED AS PRESCRIBED BY LAW.

CAUSE OF DEATH IN plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.