

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

34816
 Do not use this space.

NOV 27 1936

1. PLACE OF DEATH

(a) County Jackson Registration District No. 396

(b) Township Frank Primary Registration District No. 100

(c) City St. Joe Mo (d) Street No. H. C. Gen Hosp Registered No. 4152

(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 Mary Craine

(a) Residence, No. 1330 Forest St. (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

MEDICAL CERTIFICATE OF DEATH

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) widow

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Milton Brignard

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) July - 26 - 1894

| 7. AGE | YEARS | MONTHS | DAYS | If LESS than 1 day, hrs. or min. |
|--------|-------|--------|------|----------------------------------|
| 97 | | 2 | 28 | |

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. none

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) Mo. U.

FATHER

13. NAME Unknown

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Unknown

17. INFORMANT (ADDRESS) Resident Clerk H. C. Gen Hosp

18. BURIAL, CREMATION, OR REMOVAL PLACE Marysville Mo DATE Oct 26 1936

19. FUNERAL DIRECTOR (NAME) (ADDRESS) A. R. Dorkler 1415 E 15

20. FILED 10-25-36 M. M. Craine Local Registrar.

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 10-24-38

22. I HEREBY CERTIFY, That I attended deceased from 10-18-38, 19... to 10-24-38, 19... last saw her alive on 10-24-38, 19... Death is said to have occurred on the date stated above, at 1:30 p.m.

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

Pneumonia, Secondary to Fracture of hip. Date of onset 1936

Other contributory causes of importance: Arteriosclerotic Heart

Name of operation..... Date of.....

What test confirmed diagnosis?..... Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? Yes Date of injury Unknown

Where did injury occur? X 6 Mo (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury Acc fall

Nature of injury.....

24. Was disease or injury in any way related to occupation of deceased? If so, specify.....

(Signed) P. D. De Marco M.D.

(Address) Hosp H. C. Gen Hosp

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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 _____

Registered Apprentice No. _____, working under my personal supervision.

Signed *A.P. Hoehler*

Licensed Embalmer No. *1166*

P. O. Address *1415 E 15*

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