DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

JAN 23 1949

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 44954

Registration District No. 892 | Primary Registration District No. 6194 | Registrar's No. 22

1. PLACE OF DEATH:

(a) County: Wayne Black Pine

(b) City or town: Chaonia, Mo.
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location) 3

(d) Length of stay: In hospital or institution (Specify whether years, months or days) In this community

2. USUAL RESIDENCE OF DECEASED: 1

(a) State: Missouri (b) County: Wayne

(c) City or town: Chaonia, Mo.
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME: Martha E. Critchfield 632

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: F

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widow

6. (b) Name of husband or wife: Samuel

6. (c) Age of husband or wife if alive years

7. Birth date of deceased: Oct. 26, 1868 (Month) (Day) (Year)

8. AGE: Years 71 | Months 2 | Days 5 | If less than one day hr. min.

9. Birthplace: Wayne County, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation: Housewife

11. Industry or business: 9

MOTHER FATHER

12. Name: Unknown

13. Birthplace (City, town, or county) (State or foreign country) 9

14. Maiden name: Unknown

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Elizabeth Sanderson

(b) Address: Chaonia, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Jan. 1, 1940 (Month) (Day) (Year)

(c) Place: burial or cremation: Thornton near Kime

18. (a) Signature of funeral director: Greer-Croy Service

(b) Address: Poplar Bluff, Mo. 8116

19. (a) Jan. 1, 40 (Date received local registrar) (b) Mrs. Pattie McPhee (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Dec. 31 day year 1939 hour 12 Noon minute M.

21. I hereby certify that I attended the deceased from 12-15, 1939, to 12-31, 1939, that I last saw h. alive on 12-15, 1939, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Uraemic poisoning	
Due to: Chronic interstitial nephritis	
Chronic myocarditis	
Due to: Arteriosclerosis.	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations: none	
Of autopsy: none	

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PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) —

(b) Date of occurrence —

(c) Where did injury occur? — (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? —
(Specify type of place)

While at work? — (e) Means of injury —

23. Signature: H. M. Henderson (M. D. or other) Henderson

Address: Poplar Bluff Mo. Date signed 1-6-40

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 I X19511

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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.....

Licensed Embalmer No.....

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