DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 508
508

Registration District No. 791
Primary Registration District No.
Registrar's No.

1003

1. PLACE OF DEATH:
(a) County
(b) City or town St. Louis, Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: St. John's Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State Illinois (b) County
(c) City or town Duquoin NR
(If outside city or town limits, write "RURAL")
(d) Street No. 613 N. Washington
(If rural, give location)
(e) If foreign born, how long in U. S. A.? years.

3. (a) PRINT FULL NAME Emory Otis Crain
3. (b) If veteran, name war No.
3. (c) Social Security No. 343-05-5113
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Minnie
6. (c) Age of husband or wife if alive 54 years
7. Birth date of deceased Oct. (Month) 28 (Day) 1881 (Year)
8. AGE: Years 58 Months 2 Days 19 If less than one day hr. min.
9. Birthplace Vergennes (City, town, or county) Illinois (State or foreign country)
10. Usual occupation Street Com. Duquoin, Ill.
11. Industry or business
MOTHER FATHER
12. Name Samuel Crain
13. Birthplace (City, town, or county) Illinois (State or foreign country)
14. Maiden name Louisa Henson
15. Birthplace (City, town, or county) Illinois (State or foreign country)
16. (a) Informant's own signature Mrs. Minnie Crein
(b) Address Duquoin, Ill.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof 1/19/40 (Month) (Day) (Year)
(c) Place: burial or cremation Duquoin, Ill.
18. (a) Signature of funeral director Albert H. Hoppe.
(b) Address 4700 Washington Ave. St. L.
19. (a) JAN 18 1940 (Date received local registrar) (b) [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17 year 1940 hour one P.M. minute M.
21. I hereby certify that I attended the deceased from Dec. 23, 1939 to Jan. 17, 1940, that I last saw him alive on Jan. 17, 1940, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardio-vascular failure	2 days
Due to: Diabetes mellitus	3 yrs
Due to: Calculous left renal	1 yr
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operation: Calculous left renal	
Of autopsy:	

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)
(e) While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address [illegible] Date signed Jan 18, 40

(Licensed Embalmer's Statement on Reverse Side)

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.

Rev. 5-17-39
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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 J. G. Sullivan

Licensed Embalmer No. 1123

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.