

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No.

FILED FEB 21 1940

Registration District No.

575

Primary Registration District No.

57110

Registrar's No.

1. PLACE OF DEATH:

(a) County Montgomery
(b) City or town Festina (Rural)
(c) Name of hospital or institution: at home
(d) Length of stay: In hospital or institution 4 years
In this community 4 years

3. (a) PRINT FULL NAME Green Berney Crain

3. (b) If veteran, name war no (c) Social Security No. none

4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Nora B. Crain 6. (c) Age of husband or wife if alive 58 years

7. Birth date of deceased March 14 1875

8. AGE: Years 64 Months 10 Days 25 If less than one day hr. 2 min.

9. Birthplace Linco Creek (City, town, or county) (State or foreign country) Mo.

10. Usual occupation Farmer

11. Industry or business Farm

12. Name Louisa Crain

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

14. Maiden name Amelia J. Ballenger

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

16. (a) Informant's own signature Nora B. Crain

(b) Address Festina Mo.

17. (a) K.E. Mo. (b) Date thereof 2-11-40

(c) Place: burial or cremation K.E. Mo.

18. (a) Signature of funeral director Jemelle G. Richards

(b) Address Festina Mo.

19. (a) 2-10-40 (b) Mrs. A. C. M. E.

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Montgomery
(c) City or town Festina Rural
(d) Street No. 0
(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 9th year 1940 hour 4:30 minute P. M.

21. I hereby certify that I attended the deceased from Oct. 10, 1937 to Oct. 27, 1940 that I last saw him alive on Oct. 27, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis 5 yrs Duration 5 yrs

Due to _____
Due to _____
Other conditions (Include pregnancy within 3 months of death) _____

Major findings: Of operations _____
Of autopsy _____

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? _____

23. Signature P. F. Eckhoff (M. D. or other) PO
Address Versailles Mo. Date signed 2/9/40

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

Rev. 6-17-39 I X1931

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 me

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

Signed J. Annee - E. Richards
Licensed Embalmer No. 2466
P. O. Address Lipton 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 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

Do not use this space.

1. PLACE OF DEATH

(a) County Morgan Registration District No. 575
 (b) Township WILLOW FORK Primary Registration District No. 4339 Registered No. _____
 (c) City Fortuna Rural (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 1 yrs. 0 mos. 0 ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME Green Bery Crain

(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 m 4. COLOR OR RACE w 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) sn

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

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

7. AGE YEARS 64 MONTHS 10 DAYS 25 If LESS than 1 day, _____ hrs. or _____ min.

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) Jessie Z. Richard

20. FILED 2-12 1940 Mrs C. E. Frye Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 2-9 1940

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:

Date of onset

Other contributory causes of importance:

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) P. J. Eckhoff, M. D.

(Address) Verona

SUPPLEMENTARY

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.

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

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