

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

10667
Do not use this space.

1. PLACE OF DEATH
 (a) County Clay Registration District No. 201
 (b) Township Liberty 3 Primary Registration District No. 5550 Registered No. 25
 (c) City Liberty (d) Street No. ambulance on street 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 Anna Mary Foley Crabtree
 (a) Residence, No. Missouri City, Mo. 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 OR (OR) WIFE OF James A. Crabtree

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Feb 14 - 1874

| | | | | |
|--------|-----------|----------|-----------|--|
| 7. AGE | YEARS | MONTHS | DAYS | IF LESS than 1 day, hrs. or min. |
| | <u>66</u> | <u>0</u> | <u>18</u> | |

OCCUPATION
 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. housewife
 9. Industry or business in which work was done, as saw mill, bank, etc. for beef
 10. Date deceased last worked at this occupation (month and year) 4 mo ago 11. Total time (years) spent in this occupation 45

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri City, Mo.

FATHER
 13. NAME Little Berry Foley
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Key, Va.

MOTHER
 15. MAIDEN NAME Emma Kathryn George
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Va.

17. INFORMANT (ADDRESS) Mrs E. H. Miller, Carrier, Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Missouri City, Mo. DATE Mar 4 - 1940

19. FUNERAL DIRECTOR (ADDRESS) Chm of - churches, Liberty, Mo.

20. FILED April 9, 1940 W. H. Shaffer Local Registrar.

MEDICAL CERTIFICATE OF DEATH

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

22. I HEREBY CERTIFY, That I attended deceased from overseen, 19.....
 I last saw h. alive on 3 PM, 1940 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:
Chronic myocarditis
 Date of onset

Other contributory causes of importance:
obstruction of the Bowel

Name of operation none Date of.....
 What test confirmed diagnosis? Physical Exam an autopsy? no

23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide?..... Date of injury....., 1940
 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) Mrs. J. H. ... (Address) Liberty, Mo.

COPY WITH GRADING INK---THIS IS 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 im-

92C

STATEMENT BY LICENSED EMBALMER

I, Edgar Archer, Licensed Embalmer No. 2311

hereby certify that the body recorded on the reverse side of this certificate was embalmed by Edgar Archer

..... L. E.

No. 3311 or by, Registered Apprentice No.

working under my personal supervision.

Signed Edgar Archer

Licensed Embalmer No. 2311

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.)

MISSOURI STATE BOARD OF HEALTH
 STANDARD CERTIFICATE OF DEATH

State File No. 10667

DEPARTMENT OF COMMERCE
 BUREAU OF THE CENSUS

Registration District No. 201

Primary Registration District No. 3012

Registrar's No. 2d-

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

1. PLACE OF DEATH:

(a) County Clay
 (b) City or town Liberty
(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)
 (d) Length of stay: In hospital or institution.
 In this community (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State _____ (b) County _____
 (c) City or town _____
(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 Donna Mary Foley Crabtree

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife _____ 6. (c) Age of husband, or wife, if alive _____ year

7. Birth date of deceased. (Month) (Day) (Year)

8. AGE: Years Months Days If less than one year
66 0 18 hr. min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER { 12. Name _____

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

14. Maiden name _____

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

16. (a) Informant _____

(b) Address _____

17. (a) _____ (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Mar day 2
 year 1940 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
 that I last saw h. _____ alive on _____, 19____,
 and that death occurred on the date and hour stated above.

Immediate cause of death Chronic Myocarditis

Due to _____

Due to _____

Other condition obstruction of bowels
(Include pregnancy within 3 months of death)

Major findings: Of operation carcinoma of colon

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?

While at work? _____
(Specify type of place) (e) Means of injury

23. Signature Mrs W B Weyong (M.D. or other)
 Address Liberty Date signed _____

SUPPLEMENTAL

S-10667

1940