

FILED JUN 1 1940

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

18325

Do not use this space.

1. PLACE OF DEATH

(a) County Franklin Registration District No. 288
(b) Township Clay Primary Registration District No. 241 Registered No. 18325
(c) City or Arbuda Mo (d) Street No. _____ 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

(a) Residence, No. Joe Nell Crossand 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 <u>Female</u>	4. COLOR OR RACE <u>W.</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)		
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF				
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) <u>Feb 5 - 1940</u>				
7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>0</u>	<u>2</u>	<u>30</u>	
OCCUPATION	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. <u>Baby</u>			
	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) <u>Arbuda Mo</u>				
FATHER	13. NAME <u>Wm Henry Crossand</u>			
	14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ark</u>			
MOTHER	15. MAIDEN NAME <u>Viola Ford</u>			
	16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) <u>Ark</u>			
17. INFORMANT <u>Brother R. L. Crossand</u> (ADDRESS) <u>Arbuda Mo. R. 1</u>				
18. BURIAL, CREMATION, OR REMOVAL PLACE <u>Famian Ark</u> DATE <u>5-5-40</u>				
19. FUNERAL DIRECTOR (NAME) <u>Kirby Und. Co.</u> (ADDRESS) <u>Rectory - 3-5-1</u>				
20. FILED <u>5-4</u> 19 <u>40</u> <u>Thurson</u> Local Registrar.				

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) _____, 19 _____

22. I HEREBY CERTIFY, That I attended deceased from 4-23, 19 40, to 5-4, 19 40
I last saw her alive on 4-28, 19 40. Death is said to have occurred on the date stated above, at 2:15 P.M.
The principal cause of death and related causes of importance were as follows:
Bronchopneumonia Date of onset 3-26

Other contributory causes of importance: malnutrition

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? NO
If so, specify _____
(Signed) W. Stoughton, M. D.
(Address) Cardwell Mo

1072

RECEIVED

District Health Officer No. 2

District File Number 540-101

Date Filed 5/27/40

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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18328

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 283

Primary Registration District No. 3402

Registrar's No.

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

1. PLACE OF DEATH: *Dunklin*
 (a) County *Dunklin*
 (b) City or town *Buffalo*
 (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 _____ (Specify whether _____)
 In this community _____ (Specify whether _____)
 years, months or days

3. (a) PRINT FULL NAME *Joe Nell Croas*
 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 _____
 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 day
 _____ 2 30 _____ 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)
 (Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) *10-11-40* (b) *J. H. Newsom*
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:
 (a) State *mo* (b) County *Dunklin*
 (c) City or town *Arlynd 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.

19. MEDICAL CERTIFICATION
 20. DATE OF DEATH Month *2* day *4*
 year _____ 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 *Bronchitis pneumonia*
 Duration _____

Due to *none*
 Due to _____

Other conditions _____ (Include pregnancy within 3 months of death)
 107W

Major findings:
 Of operations _____
 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 *W. D. English* (M. D. or other) _____
 Address *Cardwell mo.* Date signed _____

SUPPLEMENTARY

2B
-40
22659

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 18325-

Registration District No. 283

Primary Registration District No. 3402

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
(b) City or town Buffalo
(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)

3. (a) PRINT FULL NAME Joe Nell Crossno

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 _____

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

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

8. AGE: Years _____ Months 2 Days 3 If less than one day _____ 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)
(Burial, cremation, or removal)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 5-4-40 (b) [Signature]
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Franklin
(c) City or town Arlyrd, 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.

MEDICAL CERTIFICATION

20. DATE OF DEATH Month May day 4
year 1940 hour 3 minute 15 P.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 _____

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?

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

23. Signature _____ (M. D. or other) _____

Address _____ Date signed _____

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

WRITE PLAINLY—USE UNFADING INK—MAKE A PERMANENT RECORD