

WRITE PLAINLY, WITH UNFADING 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 important.

JUN 14 1940

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

18572
Do not use this space.

1. PLACE OF DEATH
 (a) County Howard Registration District No. 319
 (b) Township _____ Primary Registration District No. 4223
 (c) City Glasgow Mo. (d) Street No. _____ St. _____
 (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 MARY APEL CRIGLER
 (a) Residence, No. Glasgow Mo. St. (If nonresident, give city or town and State)

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 OF (OR) WIFE OF Victor Crigler
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 7-14-1878
 7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 61 10 14
 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. Home
 10. Date deceased last worked at this occupation (month and year) Oct. 1935 11. Total time (years) spent in this occupation 40
 12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Herman Mo.
 FATHER 13. NAME Henry Apel
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Missouri
 MOTHER 15. MAIDEN NAME Amelia Saeger
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Germany
 17. INFORMANT (ADDRESS) Victor Crigler Glasgow Mo.
 18. BURIAL, CREMATION, OR REMOVAL PLACE Glasgow Mo. DATE June 3 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Walker Audsley Glasgow Mo.
 20. FILED 5-31 1940 J. W. Gardner M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) May 31 1940
 22. I HEREBY CERTIFY, That I attended deceased from May 1 1940 to May 31 1940
 I last saw her alive on May 30 1940 Death is said to have occurred on the date stated above, at 11:20 P.M.
 The principal cause of death and related causes of importance were as follows:
Carcinoma of Ovary & Uterus!
 Date of onset _____
 Other contributory causes of importance: _____
 Name of operation none Date of _____
 What test confirmed diagnosis? clinical Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? no 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) W. B. Stitchen M. D.
Glasgow (Address)

48

RECEIVED
District Health Officer No. B,
Date Filed 6-7-40

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,

J. Walker Airdley or by

Registered Apprentice No., working under my personal supervision.

Signed *J. Walker Airdley*

Licensed Embalmer No. *3336*

P. O. Address *Glasgow 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.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 185-72

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 379

Primary Registration District No. 4223

Registrar's No.

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

MOORE

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Wasson
(If outside city or town limits, give "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 Mary apel Crigler

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 in

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 Days If less than one day
61 10 14 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)

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.

19. MEDICAL CERTIFICATION
20. DATE OF DEATH Month May day 31 year _____ hour _____ minute _____ M.

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

Immediate cause of death Carcinoma of esophagus & uterus, probably ovarian.
Due to I only saw this patient about 3 weeks before she died
Due to _____

Other conditions (include pregnancy within 3 months of death) 49

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 W. B. Kitchin (M. D. or other) _____
Address Wasson Date signed _____

Duration of _____
PHYSICIAN
Underline the cause to which death should be charged statistically.

SUPPLEMENTAL COPY

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 185-72

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 379

Primary Registration District No. 4223

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Howard
(b) City or town Blasgow
(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 _____ years, months or days)

3. (a) PRINT FULL NAME

Mary Apel Crigler

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) 7 (Day) 14 (Year) 1871

8. AGE:

Years 61 Months 10 Days 14 If less than one year 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 _____

(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) 7-4-40

(Date received local registrar)

(b) J. B. Kitchener

(Registrar's signature)

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.

20. MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 31
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 _____

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

Duration

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) _____ (Means of injury)

23. Signature W. B. Kitchener (M. D. or other) _____

Address Blasgow _____