

JUN 22 1940

STANDARD CERTIFICATE OF DEATH

State File No. 90

Registration District No.

Primary Registration District No. 6050

Registrar's No.

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Rural, Liberty Twp.
(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 _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler
(c) City or town Rural
(If outside city or town limits, write "RURAL")
(d) Street No. Lancaster
(If rural, give location)
(e) If foreign born, how long in U. S. A. _____ years.

8. (a) PRINT FULL NAME Frances Marion Crom

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

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

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

7. Birth date of deceased March 25, 1905
(Month) (Day) (Year)

8. AGE: Years 35 Months 1 Days 15 If less than one day hr. 0 min. 7

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

10. Usual occupation farmer

11. Industry or business _____

12. Name Samuel P. Crom 13. Birthplace Davis Iowa
(City, town, or county) (State or foreign country)

14. Maiden name Lissy Ward 15. Birthplace Schuyler Co. Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Samuel P. Crom (b) Address Lancaster, Mo.

17. (a) Burial (b) Date thereof May 12, 1940
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Crestonville, Mo.

18. (a) Signature of funeral director P. A. Denton (b) Address Lancaster, Mo.

19. (a) 5/16-40 (b) _____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 10 year 1940 hour 1 PM minute _____ M.

21. I hereby certify that I attended the deceased from May 4, 1940, to May 10, 1940; that I last saw him alive on May 10, 1940; and that death occurred on the date and hour stated above.

Immediate cause of death Hemorrhage in Bowel

Due to Peptic Ulcer

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)
(c) Means of injury _____

23. Signature R. E. Vaughn (M., D., or other) 320.
Address Lancaster, Mo Date signed May 12, 1940

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

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

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RECEIVED

District Health Officer No. 10

District File Number 6-40-1233

Date Filed JUN 12 1948

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

P. O. Fenton

Registered Apprentice No. 3705

working under my personal supervision.

Signed P. O. Fenton

Licensed Embalmer No. 3705

P. O. Address Lancaster, 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. 19681

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 805

Primary Registration District No. 6050

Registrar's No. _____

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

1. PLACE OF DEATH:

(a) County Schuyler
(b) City or town Liberty, Mo.
(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 Frances Marion Cron

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

4. Sex m 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 35 Months 1 Days 5 If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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) Feb 12 1948 Berdi H. Dyke (Registrar's Signature) _____ (Date received local registrar)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler
(c) City or town Rural (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 10
year 1948 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____; that last saw him _____ 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) _____ (c) Manner of injury _____

23. Signature R. E. Vaughan (M. D. or other) _____

Address Lancaster Mo Date signed _____

SUPPLEMENTARY

