

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

## STANDARD CERTIFICATE OF DEATH

State File No. **31373**Registration District No. **73**Primary Registration District No. **3006**Registrar's No. **197**

## 1. PLACE OF DEATH:

(a) County **Boone**  
 (b) City or town **Columbia**  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution:  
**Boone County Hosp**  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution **3 days** **1**  
 (Specify whether  
 In this community **6 mo**  
 years, months or days)

3. (a) PRINT FULL NAME **Patricia Ann Crose**3. (b) If veteran, name war. **—** 3. (c) Social Security No. **—**4. Sex **F.** 5. Color or race **W.** 6. (a)  Single,  widowed, married,  divorced6. (b) Name of husband or wife **—** 6. (c) Age of husband or wife if alive **—** years7. Birth date of deceased **Feb 28 1940**  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
**6 9** hr. min.9. Birthplace **Columbia Mo.**  
(City, town, or county) (State or foreign country)10. Usual occupation **Infant**11. Industry or business **—**12. Name **Marshal Crose**18. Birthplace **Columbia Mo.**  
(City, town, or county) (State or foreign country)14. Maiden name **Clara Bias**15. Birthplace **Howard Co. Mo.**  
(City, town, or county) (State or foreign country)16. (a) Informant **Father - Marshal Crose**(b) Address **118 Webster Alley Columbia**17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **9-8-40**  
(Month) (Day) (Year)(c) Place: burial or cremation **Clinton Cemetery**18. (a) Signature of funeral director **Parker (W.H.)**(b) Address **Columbia Mo.**19. (a) **9/9/40** (Date received local registrar) (b) **Allie Selby** (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Boone**  
 (c) City or town **Columbia**  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. **118 Webster Alley**  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. **—** years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **7**  
year **1940** hour **8** minute **15 p. M.**21. I hereby certify that I attended the deceased from **9-5** 1940 to **9-7** 1940that I last saw her alive on **9-7** 1940 and that death occurred on the date and hour stated above.Immediate cause of death **Inanition / Terminal pneumonia (Bronchitis)**Due to **—** Duration **?**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? **74** (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 **J. M. Blair M.D.** (M. D. or other) **!**Address **Boone County Hospital** Date signed **9-8-40**

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

MOTHER FATHER

107a

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**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. **31373**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. **73**

Primary Registration District No. **3006**

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County **Boone**  
(b) City or town **Columbia**  
(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 **Patricia Ann Cross**

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

4. Sex **F** 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 **5** Months **6** Days **9** If less than one day \_\_\_\_\_ hr \_\_\_\_\_ 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) \_\_\_\_\_ (b) \_\_\_\_\_ (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. DATE OF DEATH: Month **Sept** day **7** year **1970** hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_ that I have seen him \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above.

Immediate cause of death **Terminal Pneumonia (Bronchial)**  
Due to \_\_\_\_\_  
Due to **NO complications**

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 **J. H. Pinf** \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
**Boone Co. Health** \_\_\_\_\_ Date signed \_\_\_\_\_  
**Columbia Mo**

SUPPLEMENTAL COPY

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

