

1940 OCT 10 1940

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **32020**

Registration District No. **318**

Primary Registration District No. **2001**

Registrar's No. **735**

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

9310

1. PLACE OF DEATH:

(a) County **GREENE**  
(b) City or town **Springfield**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
**Burge Hospital**  
(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

2. USUAL RESIDENCE OF DECEASED:

(a) State **Illinois** (b) County **Adams**  
(c) City or town **Loraine**  
(If outside city or town limit, 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 **Sept** day **8**  
year **1940** hour **12** minute **45** M.

21. I hereby certify that I attended the deceased from **9-3-** 19**40** **9-8-** 19**40**  
that I last saw him alive on **9-8-40** 19**40**;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Resenteric Thrombosis**  
Duration \_\_\_\_\_

Due to \_\_\_\_\_  
Due to **again**

Other conditions (include pregnancy within 3 months of death) \_\_\_\_\_

Major findings: Of operations \_\_\_\_\_  
Of autopsy **Resenteric Thrombosis**  
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?  
**again**

23. Signature **Henry G. Krapf** (M. D. \_\_\_\_\_)  
Address **450 1/2 E. Council St** Date signed **9/8/40**

8. (a) PRINT FULL NAME **Riley S. Crank**

3. (b) If veteran, name war **no** 3. (c) Social Security No. **none**

4. Sex **Male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widower**

6. (b) Name of husband or wife **Florence Crank** 6. (c) Age of husband or wife if alive **Dec** years

7. Birth date of deceased **Aug** 25, 1873  
(Month) (Day) (Year)

8. AGE: Years **67** Months **0** Days **13** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **Farmer**

11. Industry or business **On Farm**

12. Name **James R. Crank**

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

14. Maiden name **Nancy E. Spence**

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

16. (a) Informant **Mrs. Geo. Hardy**

(b) Address **Loraine, Illinois**

17. (a) **Removal** (b) Date thereof **9-8-40**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Loraine, Ill.**

18. (a) Signature of funeral director **Alma Schreyer**

(b) Address **Springfield, Mo**

19. (a) **Sept 8, 1940** (b) **W. E. Handley MD**  
(Date received local registrar) (Registrar's signature)

**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 Harlow Knobl

Licensed Embalmer No. 4065

P. O. Address Springfield 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.**

X