

No. 2
-36
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32394**

Registration District No. **110 OCT 28 1940**

Primary Registration District No. **4279**

Registrar's No. **14**

1. PLACE OF DEATH:

(a) County Lafayette

(b) City or town Wellington
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: none
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution none **20**
(Specify whether years, months or days)

In this community about 55 years

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lafayette

(c) City or town Wellington
(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.

3. (a) PRINT FULL NAME CARRIE S. CREWS

3. (b) If veteran, name war _____

3. (c) Social Security No. none

4. Sex Female 5. Color or race white

6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife William B 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased April 17 1878
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
			hr. min.

9. Birthplace: St Charles Co Mo. **0**
(City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business House work

MOTHER { 12. Name Fred Gausman

13. Birthplace Warren Co Mo.
(City, town, or county) (State or foreign country)

14. Maiden name Kulshuman

15. Birthplace Germany
(City, town, or county) (State or foreign country)

16. (a) Informant William B Crews

(b) Address Wellington Mo

17. (a) burial (b) Date thereof April 15-1940
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Cely Cemetery

18. (a) Signature of funeral director Wm Ewen

(b) Address Wellington Mo 412

19. (a) _____ (b) F M Mann
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day April
year 1940 hour 9:30 minute P M.

21. I hereby certify that I attended the deceased from April 12th
1940 to April 12 1940

that I last saw her alive on April 12 1940
and that death occurred on the date and hour stated above.

Immediate cause of death Bored to death
clothes caught fire
while cleaning oil stove

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 R. B. Watts (M. D. or other) 1
Address Wellington Mo Date signed 4-12-40

PHYSICIAN

Duration _____

Underline the cause to which death should be charged statistically.

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

181/5

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-11-40

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 *W. P. Egan*
Licensed Embalmer No. *3070*
P. O. Address *Wellington 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.

2
-2-11-40
X22859

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **32394**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **466**

Primary Registration District No. **4279**

Registrar's No. _____

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

1. PLACE OF DEATH

(a) County **Lafayette**

(b) City or town **Wellington**
(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 **Carrie S. Crews**

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 _____ Days _____ 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** _____

(Burial, cremation, or removal) (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.

20. DATE OF DEATH Month **12** day **12** year **1940** 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 **Burned to death**

Due to **Clothes caught fire while cleaning oil stove**

Due to **House did not burn**

Other conditions **accident occurred at home.**

(Include pregnancy within 3 months of death)

PHYSICIAN _____

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 **P. B. Watts** (M. D. or other) _____

Address **Wellington, Ky.** **Date signed** **11/14/40**

SUPPLEMENTAL

Underline the cause to which death should be charged statistically.

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