

STANDARD CERTIFICATE OF DEATH

State File No. 35726

Registration District No. H 90

Primary Registration District No. 470 5657

Registrar's No. 6

1. PLACE OF DEATH:

(a) County Lincoln
 (b) City or town Siles
 (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 20
 In this community This Community
 years, months or days

8. (a) PRINT FULL NAME Mary Alice Croner

8. (b) If veteran, name war _____ 8. (c) Social Security No. _____

4. Sex Female 5. Color or race Dr
 6. (a) Single, widowed, married, divorced widowed

6. (b) Name of husband or wife James Croner
 6. (c) Age of husband or wife if alive dead years

7. Birth date of deceased Dec 7-1823
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
66 10 24 hr. min.

9. Birthplace Lincoln Co Mo
 (City, town, or county) (State or foreign country)

10. Usual occupation Housekeeping

11. Industry or business _____

12. Name Patrick McCarty

13. Birthplace Ireland
 (City, town, or county) (State or foreign country)

14. Maiden name Sarah Ann Shuckler

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

16. (a) Informant Mary A. Croner
 (b) Address Siles Mo.

17. (a) Burial (b) Date thereof 10-3-1940
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Millwood

18. (a) Signature of funeral director Rev. Father Carr
 (b) Address Siles Mo.

19. (a) 10-2-1940 (b) O. H. Dawson
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Lincoln
 (c) City or town Siles Mo. 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 Oct. day 1-1
 year 1940 hour 4 minute 30 A. M.

21. I hereby certify that I attended the deceased from January 20 1940, to Oct-12 1940
 that I last saw her alive on Sept 29 1940
 and that death occurred on the date and hour stated above.

Immediate cause of death Cancer of sigmoid flexura and rectum
 Due to _____
 Due to _____
 Other conditions _____
 (Include pregnancy within 3 months of death)

PHYSICIAN
 Major findings: Cancer of Colon and Rectum
 Of operations _____
 Of autopsy No.
 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?
439 (Specify type of place) _____
 While at work? _____ (e) Means of injury _____
 23. Signature O. H. Dawson (M. D. or other) _____
 Address Siles Mo. Date signed 10-2-40

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

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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 me

....., Registered Apprentice No.
working under my personal supervision.

Signed W. R. Dammund

Licensed Embalmer No. 2251

P. O. Address Silet 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. **35-726**

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. **490**

Primary Registration District No. **0609**

Registrar's No. _____

1. PLACE OF DEATH:
 (a) County Linn, Mo.
 (b) City or town Millersburg, Mo.
 (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 _____ (Specify whether years, months or days)

3. (a) PRINT FULL NAME Mary Alice Cronen
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 wid
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 66 Months 10 Days 24
 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)
 (Burial, cremation, or removal)

(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.

MEDICAL CERTIFICATION
20. DATE OF DEATH Month Oct day 1
 year 1940 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 Cancer of sigmoid
Colon & Rectum
 Due to _____
 Due to _____ 46

Other conditions Cancer of colon and rectum
 (Include pregnancy within 3 months of death)
 Major findings: Cancer started in rectum involved the entire colon
 Of a topology _____

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) _____ (e) Means of injury _____

23. Signature OT of Cronen (M. D. or other) yes
Address Siles, Mo. **Date signed** _____

SUPPLEMENTAL

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

MISSOURI STATE BOARD OF HEALTH

