

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

39956
Do not use this space.

FILED DEC 27
Stone
McKinley

1. PLACE OF DEATH
 (a) County Stone Registration District No. 844
 (b) Township McKinley Primary Registration District No. 6250 Registered No. 1
 (c) City _____ (d) Street No. _____ St.
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME John Crabtree
 (a) Residence, No. Galena no RR 2 St. (If nonresident, give city or town and State)
 Usual place of abode, if no street address, write county or city

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married
 5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Kate Crabtree
 6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 17 / 1866
 7. AGE YEARS 74 MONTHS _____ DAYS 5 If LESS than 1 day, _____ hrs. or _____ min.
 OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Farmer
 9. Industry or business in which work was done, as saw mill, bank, etc. _____
 10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 23, 1940
 22. I HEREBY CERTIFY, That I attended deceased from Oct 23, 1940, to Oct 23, 1940
 I last saw him alive on Oct 23, 1940. Death is said to have occurred on the date stated above, at 12 P. m.
 The principal cause of death and related causes of importance were as follows:
Albuminuria (acute)
Chronic Gastritis
 Date of onset 2 wks
17
 Other contributory causes of importance:
General Toxemia

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Mo.
 FATHER 13. NAME John Crabtree
 14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
 MOTHER 15. MAIDEN NAME SUZANNA Marcus
 16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Don't know
 17. INFORMANT (ADDRESS) Raymond Fildner Galena RR 2
 18. BURIAL, CREMATION, OR REMOVAL PLACE Locust Point Cem. DATE Oct 24, 1940
 19. FUNERAL DIRECTOR (NAME) (ADDRESS) Everett Chestnut Galena no
 20. FILED 10-24, 1940 Ala. Tragers Local Registrar.

Name of operation _____ Date of _____
 What test confirmed diagnosis? _____ Was there an autopsy? _____
 23. If death was due to external causes (violence), fill in also the following:
 Accident, suicide, or homicide? _____ Date of injury _____, 19____
 Where did injury occur? _____ (Specify city or town, county, and State)
 Specify whether injury occurred in industry, in home, or in public place. _____
 Manner of injury _____
 Nature of injury _____
 24. Was disease or injury in any way related to occupation of deceased?
 If so, specify Yes
 (Signed) R. S. Sheen, M. D.
 (Address) Peeds Springs no

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

12013
RECEIVED

District Health Officer No. 6,

District File Number 7240-2966

Date Filed DEC 9 1940

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. 399567
Registrar's No. _____

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 844

Primary Registration District No. 6250

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

DUPLICATE

1. PLACE OF DEATH

(a) County Stone
(b) City or town McKinley 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 _____ (Specify whether
In this community _____ (Specify whether
years, months or days)

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.

3. (a) PRINT FULL NAME John Crabtree

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 m

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 74 Months - 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 _____

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 _____ (Month) _____ (Day) _____ (Year)
(Burial, cremation, or removal) _____
(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____ (Specify type of place)
(b) Address _____ (c) Means of injury _____

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

NEEDLE CERTIFICATION

20. DATE OF DEATH Month Oct day 23
year _____ 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 albuminuria (acute)

Due to Chr. Gastritis

Due to Gastroenteritis

Other conditions General Toxemia
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy _____

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) Means of injury _____

23. Signature H. S. Shewate M.D. (M. D. or other)
Address Peeds Spring rd Date signed 1/30/77

1940

S-39956