1975

V. S. No. 2
M—11-10-39
Rev. 5-17-39
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DEC 11 1940

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 39999

Registration District No. 875 Primary Registration District No. 6162 Registrar's No. 278

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

1. PLACE OF DEATH:

(a) County: Vernon

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

(c) Name of hospital or institution: State Hospital No 3. Nevada, Mo (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 mo & 20 days (Specify whether years, months or days)

In this community 2

2. USUAL RESIDENCE OF DECEASED:

(a) State: Mo (b) County: Dade

(c) City or town: Greenfield (If outside city or town limits, write "RURAL")

(d) Street No.: Not known. (If rural, give location)

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(e) If foreign born, how long in U. S. A.? ____ years.

3. (a) PRINT FULL NAME: James R. CRANK

3. (b) If veteran, name war: ____

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

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

6. (b) Name of ~~husband or~~ wife: Mrs. Sarah Crank

6. (c) Age of husband or wife if alive: 73 years

7. Birth date of deceased: Nov (Month) 15th (Day) 1862 (Year)

8. AGE: Years 77 Months 11 Days 22 If less than one day ____ hr. ____ min.

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

10. Usual occupation: Retired minister

11. Industry or business: /

MOTHER FATHER

12. Name: James R. Crank

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

MOTHER

14. Maiden name: Nancy Spicer

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

16. (a) Informant: State Hospital Records.

(b) Address: Nevada, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-40 (Month) (Day) (Year)

(c) Place: burial or cremation Greenfield Mo

18. (a) Signature of funeral director: L. W. Wood

(b) Address: Greenfield Mo.

19. (a) 11-7-40 (Date received local registrar) (b) Allen Hays (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 7th year 1940 7 hour 45 minute A. M.

21. I hereby certify that I attended the deceased from Sept 17th, 1940, to Nov 7th, 1940 that I last saw him alive on Nov 6th, 1940 and that death occurred on the date and hour stated above.

Immediate cause of death: Senility c Senile dementia

Due to: 97

Due to: ____

Other conditions: Gen. arterio sclerosis (mild) (Include pregnancy within 3 months of death)

Major findings: Of operations: ____

Of autopsy: No

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? (Specify type of place) 2

While at work? ____ (e) Means of injury: ____

23. Signature: G. S. Warnick (M. D. ~~or other~~) 1

Address: State Hospital No 3 Nevada Mo Date signed 11/7/40

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 7,
District File Number 12-40-1688
Date Filed 12-4-40

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 J. W. Ward

Licensed Embalmer No. 2832

P. O. Address Greenfield 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.