

FILED JAN 20 1941

Registration District No. **467**

Primary Registration District No. **4280**

Registrar's No. **1**

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

1. PLACE OF DEATH:

(a) County Lawrence

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

(c) Name of hospital or institution:
at home
(If not in hospital or institution, write street number or location)

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

In this community ✓
years, months or days

3. (a) PRINT FULL NAME E. C. Crank

(b) If veteran, name war none

(c) Social Security No. none

4. Sex Male 5. Color or race white

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

(b) Name of husband or wife Mississ (c) Age of husband or wife if alive years

7. Birth date of deceased Jan 22 1964
(Month) (Day) (Year)

8. AGE: Years 77 Months 6 Days 19 hr. 0 min.

9. Birthplace Lawrence mo
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business none

MOTHER FATHER

12. Name unknown 9

13. Birthplace 11 9
(City, town, or county) (State or foreign country)

14. Maiden name unknown 9

15. Birthplace 11 9
(City, town, or county) (State or foreign country)

16. (a) Informant Charles Crank
(b) Address 38 W. Springfield St Warren mo

17. (a) Burial (b) Date thereof Jan 24 1941
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Maple Park Warren mo

18. (a) Signature of funeral director Ernest Marsh
(b) Address 229 W. Church St Warren mo

19. (a) Jan 15 1941 (b) R. D. Cowan, M.D.
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED: **56**

(a) State Missouri (b) County Lawrence

(c) City or town Warrens mo
(If outside city or town limits, write "RURAL")

(d) Street No. 38 W. Springfield St Warren mo
(If rural, give location)

(e) If foreign born, how long in U. S. A. 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 11 year 1941 hour 3 minute 20 P.M.

21. I hereby certify that I attended the deceased from Jan 7-4 to Jan 11 1941; that I last saw h. alive on Jan 11 and that death occurred on the date and hour stated above.

Immediate cause of death Perforation of Liver & Myocarditis

Due to 124 #

Other conditions (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) (e) Means of injury.

23. Signature M. B. Herron (M. D. or other) D
Address Warrens, mo Date signed Jan 13-41

STATE OF MISSISSIPPI DEPARTMENT OF HEALTH

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.....

[Handwritten Signature]

....., Registered Apprentice No. *none*

working under my personal supervision.

Signed..... *[Handwritten Signature]*

Licensed Embalmer No. *3812*

P. O. Address *[Handwritten Address]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to complete the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 3168

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 467

Primary Registration District No. 4280

Registrar's No.

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

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Aurora
(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) (Specify whether years, months or days)

3. (a) PRINT FULL NAME Ernest C Crane

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 June 22 1864
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day min.

76 7 19

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) 1-15-41 (b) R. D. Cowan M.D.
(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 Jan day 11
year 1941 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.....

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?
.....
(Specify type of place) (e) Means of injury.....

23. Signature W. B. Herson (M. D. or other).....

Address Aurora Date signed.....

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

