

FILED FEB 18 1941

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 4488

Registration District No. 805

Primary Registration District No. 6050

Registrar's No.

1. PLACE OF DEATH:

- (a) County Schuyler
 (b) City or town Chapin
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: 1

(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

8. (a) PRINT FULL NAME Samuel Thomas Crom8. (b) If veteran, name war none 3. (c) Social Security No. none4. Sex male 5. Color or race white 6. (a) Single, widowed, married, divorced married6. (b) Name of husband or wife Elizabeth Crom 6. (c) Age of husband or wife if alive 56 years7. Birth date of deceased Jan 15 1874
(Month) (Day) (Year)8. AGE: Years 67 Months 0 Days 13 If less than one day hr. _____ min. _____9. Birthplace Davis Iowa
(City, town, or county) (State or foreign country)10. Usual occupation farmer

11. Industry or business _____

12. Name Gilbert Crom13. Birthplace Germany
(City, town, or county) (State or foreign country)14. Maiden name Elizabeth Thomas15. Birthplace Germany
(City, town, or county) (State or foreign country)16. (a) Informant Luther Crom(b) Address Washington, Iowa17. (a) Burial (b) Date thereof Jan 29 1941
(Burial, cremation, or removal) (Month) (Day) (Year)(c) Place: burial or cremation Coatesville, Mo18. (a) Signature of funeral director G. P. Fenton(b) Address Lancaster, Missouri19. (a) 9 3 1941 (b) Byrd H. Drake
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County Schuyler
 (c) City or town 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 Jan day 28
year 1941 hour 11 minute 27 M.21. I hereby certify that I attended the deceased from Jan 24 1941, to Jan 26 1941;
that I last saw him alive on Jan 26 1941;
and that death occurred on the date and hour stated above.Immediate cause of death Cerebral Hemorrhage

Due to _____

Due to neoplasmOther 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? _____

719 _____ (Specify type of place)

While at work? _____ (e) Means of injury _____

23. Signature R. E. Vaughn (M. D. or other) DOAddress Lancaster, Mo Date signed 1-29-41

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

132

RECEIVED

District Health Officer No. 10

District File Number 2-41-337

Date Filed FEB 14 1941

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

P. O. Fenton

, Registered Apprentice No. 3705

working under my personal supervision.

Signed P. O. Fenton

Licensed Embalmer No. 3705

P. O. Address Lancaster, Md.

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. 4488

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

Registration District No. 805

Primary Registration District No. 6050

Registrar's No.

1. PLACE OF DEATH

(a) County Schuyler

(b) City or town Liberty T.P.
(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 _____)

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 Samuel Thomas Crow

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

20. DATE OF DEATH: Month Jan day 28
year 1941 hour _____ minute _____ M.

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) _____

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 Cerebral Hemorrhage

8. AGE: Years 67 Months 0 Days 13 If less than one day _____ hr. _____ min.

Due to _____

Due to nephritis chronic

Other conditions: _____ (include pregnancy within 3 months of death)

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) _____

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____ (Registrar's signature)

Major findings: _____

Of operations _____

Of autopsy _____

131 P

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. D. or other) _____

Address _____ Date signed _____

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

SUPPLEMENTARY

