

ED MAR 25 1941

Registration District No. 1171

Primary Registration District No. 6148

Registrar's No.

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Raymondville, Jackson 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 \_\_\_\_\_  
years, months or days

3. (a) PRINT FULL NAME Meda A. Krewson

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 0

4. Sex F. 5. Color or race W. 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife O. P. Krewson 6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased March 24th, 1901  
(Month) (Day) (Year)

8. AGE: Years 39 Months II Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace Texas County (City, town, or county) (State or foreign country)

10. Usual occupation House wife

11. Industry or business House hold duties

MOTHER FATHER { 12. Name James Helton  
13. Birthplace Dont know (City, town, or county) (State or foreign country)  
14. Maiden name Dont know  
15. Birthplace Dont know (City, town, or county) (State or foreign country)

16. (a) Informant O. P. Krewson  
(b) Address Raymondville Mo.

17. (a) Burial (b) Date thereof Feb. 27th 1941  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Vollmer Cemetery  
G. V. Elliott

18. (a) Signature of funeral director \_\_\_\_\_  
(b) Address Houston Mo.

19. (a) Feb. 27 - 1941 (b) Mar. Dora Gregory  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Texas  
(c) City or town Raymondville 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 Feb. day 26  
year 1941 hour 5 minute 0-0 A.M.

21. I hereby certify that I attended the deceased from FEB 1, 1941 to FEB. 26, 1941  
that I last saw her alive on FEB 14, 1941  
and that death occurred on the date and hour stated above.

Immediate cause of death PULMONARY EMBOLISM

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions PREECLAMPTIC TOXEMIA OF PREGNANCY  
(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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature [Signature] (M. D. or other) H.D.  
Address [Signature] Date signed 2-26

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

144 W

RECEIVED

District Health Officer No. 5,

District File Number 341327

Date Filed \_\_\_\_\_

**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. 8425

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

Registration District No. 1171

Primary Registration District No. 6145

Registrar's No. ....

1. PLACE OF DEATH:

(a) County Texas  
(b) City or town Jackson, T.O.  
(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)

3. (a) PRINT FULL NAME Meda a Krewson

3. (b) If veteran, name war. .... 3. (c) Social Security No. ....

4. Sex 7 5. Color or race W 6. (a) Single, widowed, married, divorced. W

6. (b) Name of husband or wife. .... 6. (c) Age of husband, or wife, if alive. .... year

7. Birth date of deceased. Mar 24 1901  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
89 11 2 hr. 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. ....  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation. ....

18. (a) Signature of funeral director. ....

(b) Address. ....

19. (a) May 3rd 1941 (b) Mrs. Dora Ungary  
(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 Feb day 26  
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. ....

Due to. ....  
Due to. ....

Other conditions. ....  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations. ....

Of autopsy. ....

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)

(g) Means of injury. ....

23. Signature L. M. Dulligan (M. D. or other).....

Address Houston Mo Date signed .....

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

SUPPLEMENTAL

S. No. 2  
1-14-41  
5-17-39  
X26390

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 8425

Registration District No. 1171

Primary Registration District No. 6145

Registrar's No. \_\_\_\_\_

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

1. PLACE OF DEATH:

(a) County Clas  
City or town Jackson  
(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)

3. (a) PRINT FULL NAME Medea Krewson  
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 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 40 Months 11 Days 2 If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ 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 \_\_\_\_\_

(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) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Feb day 26  
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 Pulmonary Embolism Duration \_\_\_\_\_  
144

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Pre Eclampsia  
(Include pregnancy within 3 months of death)  
Complication of Pregnancy

Major find: Delivery Feb 10, 1941 PHYSICIAN \_\_\_\_\_

Of autopsy \_\_\_\_\_ 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 John D. Ollman (M. D. or other) \_\_\_\_\_

Address Hunter St Date signed 5/14/41

SUPPLEMENTAL

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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.....  
....., 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, fact should be so stated above.**