DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 12 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14346

Registration District No. 211 Primary Registration District No. 5291 Registrar's No. 8

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

1. PLACE OF DEATH:
(a) County Cole.
(b) ~~City or town~~ Rural. ## Marion
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Centertown. Mo. R.F.D. #2 /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 37 Yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Cole 26
(c) City or town Rural 0
(If outside city or town limits, write "RURAL")
(d) Street No. Centertown. Mo. R.F.D. #2 0
(If rural, give location)
(e) If foreign born, how long in U. S. A.? 0 years.

3. (a) PRINT FULL NAME Millisa Jane Crutsinger

3. (b) If veteran, name war

3. (c) Social Security No. None

4. Sex Female /

5. Color or race White

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

6. (b) Name of husband or wife James F. Crutsinger

6. (c) Age of husband or wife if alive 71 years

7. Birth date of deceased May. (Month) 5 (Day) 1874 (Year)

8. AGE: Years 66 Months 11 Days 18 If less than one day hr. min.

9. Birthplace Cole Co. (City, town, or county) O Mo. (State or foreign country)

10. Usual occupation House Wife

11. Industry or business

MOTHER FATHER
12. Name William Swearndgim
13. Birthplace O Missouri (City, town, or county) (State or foreign country)
14. Maiden name Caroline Cross
15. Birthplace O Missouri (City, town, or county) (State or foreign country)

16. (a) Informant Fred Anderson
(b) Address Centertown. Mo. #1

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof April. 24. 41 (Month) (Day) (Year)
(c) Place: burial or cremation New Hope Cemt

18. (a) Signature of funeral director Rowlin Funeral Home
(b) Address California. Mo.

19. (a) 4-24-41 (Date received local registrar) (b) Ruth Mahan asst. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 23
year 1941 hour 7 minute A. M.

21. I hereby certify that I attended the deceased from 9 - 5, 1940, to 4 - 23, 1941;
that I last saw her alive on 4 - 22, 1941;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Chronic myocarditis with aortic aneurysm	6 mo
Due to Influenza	3 wks
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations none
Of autopsy none

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)
While at work? (e) Means of injury

23. Signature J. T. Leslie (M. D. or other) O
Address Jefferson City Date signed

(Licensed Embalmer's Statement on Reverse Side)

96

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 w the above constitutes grounds for revocation of license.)

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

No. 2B
4-25-41
X27852

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 14346

Registration District No. 211 Primary Registration District No. 5291 Registrar's No.

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Cole

(b) City or town Marion 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 years, months or days)

In this community

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

3. (a) PRINT FULL NAME Millisa Jane Crutsinger

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 66 Months 11 Days 18 If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER 12. Name

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

MOTHER 14. Maiden name

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

16. (a) Informant

(b) Address

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

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

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

MEDICAL CERTIFICATION

20. DATE OF DEATH Month Apr day 23 year 19 hour minute M.

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.

	Duration
Immediate cause of death Chronic Myocarditis with	
Due to aortic aneurysm	
Due to Not Syphilitic	
Influenza	
Other conditions (Include pregnancy within 3 months of death) 96	

Major findings:
Of operations Kahn & Kline test
Of autopsy for Syphilis neg.

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)

While at work? (e) Means of injury

23. Signature J. T. Leslie (M. D. or other)

Address Jefferson City Mo Date signed 6-20-4

S-14346