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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILLED OCT 8 1941

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 32719

Registration District No. 82

Primary Registration District No. 455-36070 Registrar's No.

1. PLACE OF DEATH:

(a) County Scott Richland Twp

(b) City or town Rural Rt. #.2., Sikeston
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 1½ mi. E. of Sikeston, Mo.
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether
In this community since birth
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Scott 100

(c) City or town Rural 0
(If outside city or town limits, write "RURAL")

(d) Street No. 1½ mi. E. of Sikeston 0
(If rural, give location)

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

3. (a) PRINT FULL NAME Judith Ann Crafton

3. (b) If veteran, name war X X X

3. (c) Social Security No. X X X

4. Sex Female/

5. Color or race White

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

6. (b) Name of husband or wife X X X X

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

7. Birth date of deceased Feb. (Month) 24 (Day) 1941 (Year)

8. AGE: Years 0 Months 6 Days 19 If less than one day ___ hr. ___ min.

9. Birthplace Scott County (City, town, or county) 0 Missouri (State or foreign country)

10. Usual occupation Infant

11. Industry or business Infant

FATHER
12. Name Carl C. Crafton
13. Birthplace Hoffman (City, town, or county) 0 Missouri (State or foreign country)

MOTHER
14. Maiden name Dorothy Maynard
15. Birthplace Wyatt (City, town, or county) 0 Missouri (State or foreign country)

16. (a) Informant Carl C. Crafton
(b) Address Rt. #.2., Box 30, Sikeston, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9-14-41 (Month) (Day) (Year)
(c) Place: burial or cremation Oak Grove-Charleston.

18. (a) Signature of funeral director Lair-Nunnelee Service
(b) Address Charleston, Mo.

19. (a) 10-1-41 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 13th. year 1941 hour 3 minute P. M.

21. I hereby certify that I attended the deceased from Feb. 24, 1941, to Sept 13, 1941 that I last saw her alive on Sept 13, 1941 and that death occurred on the date and hour stated above.

Immediate cause of death Acute bacillary dysentery — Duration 3 days

Due to

Due to 27a

Other conditions none
(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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Wilbur L Davis (M. D. or other) MD
Address Charleston Mo Date signed 9-15-41

742 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1641-136
Date Filed 10/6/41

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.

Not Embalmed

Signed .....

Licensed Embalmer No. .....

P. O. Address .....

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

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