

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. 36239  
Registrar's No. 160

Registration District No. 151949 6

Primary Registration District No. 3038

1. PLACE OF DEATH:

(a) County Saline  
(b) City or town Marshall  
(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 50 yrs. (Specify whether years, months or days)  
In this community 50 yrs.

3. (a) PRINT FULL NAME ELLA B. Crutchfield

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

4. Sex Female 5. Color or race Black 6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Stepleton Crutchfield 6. (c) Age of husband or wife if alive 50 years  
7. Birth date of deceased Aug. 31 1884 (Month) (Day) (Year)

8. AGE: Years 57 Months 1 Days 25 If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name George Marshall  
13. Birthplace Cooper Co. Omo. (City, town, or county) (State or foreign country)  
14. Maiden name Mary Slaughter  
15. Birthplace Cooper Co. Omo. (City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Willie Jackson

(b) Address 419 N. Lincoln Marshall Mo.

17. (a) Burial (b) Date thereof Oct. 28 1941 (Month) (Day) (Year)

(c) Place: burial or cremation Fairview

18. (a) Signature of funeral director Amplett-Lewis

(b) Address Marshall Mo.

19. (a) 10-28-41 (b) Myary Kent (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Saline  
(c) City or town Marshall (If outside city or town limits, write "RURAL")  
(d) Street No. 568 N. Sebrago (If rural, give location)  
(e) If foreign born, how long in U. S. A. ? \_\_\_\_\_ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct. day 26 year 1941 hour 3 minute 20 A.M.

21. I hereby certify that I attended the deceased from July 15, 1939, to Oct 26, 1941;  
that I last saw her alive on Oct 26, 1941;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cardio Renal Duration 4 yrs.

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

Other conditions (Include pregnancy within 3 months of death)

Major findings: 131a  
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) None  
(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? None (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature Robert Marshall (M. D. or other) \_\_\_\_\_  
Address Marshall Mo. Date signed 10-27-41

(Licensed Embalmer's Statement on Reverse Side)

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

RECEIVED  
District Health Officer No. 8,  
District File Number  
Date Filed 11-10-41

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.

Signed..... *R. W. Campbell*  
Licensed Embalmer No. *3469*  
P. O. Address *Marshall, W.*

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.