

Registration District No. 467Primary Registration District No. 4280Registrar's No. 65

1. PLACE OF DEATH:

(a) County Lawrence
 (b) City or town Aurora
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Aurora Hospital
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution Hospital 2 days
 (Specify whether
 years, months or days)

3. (a) PRINT FULL NAME Justina Cronk3. (b) If veteran,
name war.....3. (c) Social Security
No.....

4. Sex Female / 5. Color or race W
 6. (a) Single, widowed, married, divorced Married
 6. (b) Name of husband or wife G. D. Cronk
 6. (c) Age of husband or wife if alive 77 years
 7. Birth date of deceased: May 12 1871
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
70 5 29 ..hr.min.

9. Birthplace Le Grand / Iowa
(City, town, or county) (State or foreign country)10. Usual occupation Housewife

11. Industry or business.....

MOTHER FATHER
 { 12. Name Tom Romminger
 { 13. Birthplace ? / N Carolina
 (City, town, or county) (State or foreign country)
 { 14. Maiden name Not Known
 { 15. Birthplace ? / N. Carolina
 (City, town, or county) (State or foreign country)

16. (a) Informant G. D. Cronk
 (b) Address Billings Mo.
 17. (a) Removal (b) Date thereof 11-12-41
 (Burial, cremation, or removal) (Month) (Day) (Year)
 (c) Place: burial or cremation Le Grand Iowa

18. (a) Signature of funeral director J. F. King
 (b) Address Aurora Mo.
 19. (a) 11-30-41 (b) R. D. Cowan, M.D.
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Christian 22
 (c) City or town Billings 0
 (If outside city or town limits, write "RURAL") 0
 (d) Street No.
 (If rural, give location)
 (e) Citizen of foreign country? no (Yes or No)
 If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 10
 year 1941 hour 7 minute 25 A.M.

21. I hereby certify that I attended the deceased from
Oct 22 1941 to Nov. 10 1941;
 that I last saw h. e. r. alive on Nov. 10 1941;
 and that death occurred on the date and hour stated above.

Immediate cause of death Uremia ✓
 Duration 3 days

Due to Leukemia

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
 Of operations.....
 Of autopsy.....

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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 R. W. Marshall (M. D. or other) D.O.
 Address Billings, Mo. Date signed Dec. 10/41

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

RECEIVED

District Health Officer No. 6,

District File Number 1241-1801

Date Filed DEC 9 1941

SEP 12 1945

OCT 22 1945

OCT 19 1945

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..... *Herman Curridge*

Licensed Embalmer No. 3072

P. O. Address..... *Aurora Ill*

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

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

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 38680

Registration District No. 467

Primary Registration District No. 4280

Registrar's No.

1. PLACE OF DEATH:
 (a) County Lawrence
 (b) City or town Lawrence
(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 Justina Cronk
 3. (b) If veteran, name war.....
 3. (c) Social Security No.....

4. Sex M
 5. Color W race.....
 6. (a) Single, widowed, married, divorced.....
 6. (b) Name of husband or wife.....
 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased May 12, 1923
(Month) (Day) (Year)

8. AGE: Years 20 Months 5 Days 23
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.....
(Burial, cremation, or removal) (Month) (Day) (Year)
 (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..... day.....
 year..... hour..... minute..... M.
 21. I hereby certify that I attended the deceased from.....
 19.....
 that I last saw him..... alive on....., 19.....
 and that death occurred on the date and hour stated above.
 Immediate cause of death.....

Due to Chronic nephritis
 Due to.....
 Other 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?
(Specify type of place)
 While at work?..... (e) Means of injury.....
 23. Signature..... (M. D. or other).....
 Address..... Date signed.....

SUPPLEMENTARY

Duration.....
 PHYSICIAN.....
 Underline the cause to which death should be charged statistically.

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

S-38680