

DEC 23 1941

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

39706

Do not use this space.

1. PLACE OF DEATH

(a) County Ray Registration District No. 1171
(b) Township Jackson Primary Registration District No. 6145-
(c) City Ray (d) Street No. _____ Registered No. _____
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.
(If death occurred in Hospital or Institution, write its name instead of street and number) St.

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
Edith Marie Crum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) W

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF _____

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) Oct 23 - 41

7. AGE YEARS MONTHS DAYS IF LESS than 1 day, _____ hrs. or _____ min.
7

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. _____
9. Industry or business in which work was done, as saw mill, bank, etc. _____
10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Raymondville Mo

FATHER 13. NAME Herchel Crum

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Raymondville Mo

MOTHER 15. MAIDEN NAME Juanetta Hubbs

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Raymondville Mo

17. INFORMANT (ADDRESS) Herchel Crum Raymondville

18. BURIAL, CREMATION, OR REMOVAL PLACE Mrs. Mahelen DATE Oct 31 1941

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Neighbors Raymondville Mo

20. FILED Oct 31 1941 Mrs. Dora Gregory Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) Oct 30 1941

22. I HEREBY CERTIFY, That I attended deceased from Oct 23 1941 to Oct 31 1941

I last saw him alive on Oct 30 1941. Death is said

to have occurred on the date stated above, at 11 a.m.

The principal cause of death and related causes of importance were as follows:

Branchio Pneumonia Date of onset

Other contributory causes of importance: _____

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? _____

23. If death was due to external causes (violence), fill in also the following: Accident, suicide, or homicide? _____ Date of injury _____ 1941

Where did injury occur? _____ (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place? _____

Manner of injury _____ Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? _____

If so, specify _____ (Signed) Leslie Sanders M. D.

(Address) Licking Mo

RECEIVED

District Health Officer No. 5,

District File Number 11412028

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. 397.06

Registration District No. 1171

Primary Registration District No. 6145

Registrar's No. _____

1. PLACE OF DEATH:

(a) County Franklin
(b) 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)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Texas
(c) City or town Road Jackson
(If outside city or town limits, write "RURAL")
(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 Oct Day 31 Year 1941 hour 10 minute 30 P. M.
21. I hereby certify that I attended the deceased from Oct. 31 1941
that I last saw him alive on _____ 1941
and that death occurred on the date and hour stated above.
Immediate cause of death _____
Duration _____

3. (a) PRINT FULL NAME Cliff M. Cum

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

4. Sex M. 5. Color of race W 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 Oct. 23 (Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ (if less than one day _____ min.)

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

10. Usual occupation _____

11. Industry of business _____

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) Do not know (b) _____ (Date received local registrar) (Registrar's signature)

Due to _____
Due to then Broncho Pneumonia
I do not know why.
Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations none
Of autopsy none 101

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) no
(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) (b) Means of injury _____

23. Signature Leslie Kendall (M. D. or other) MD
Address Licking MO Date signed 1-10-42

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

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