. S. No. 2
—11-10-39
v. 5-17-39
I X21492

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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

11307

State File No.

FILED APR 2 1942 546

Registration District No.

Primary Registration District No. 5735

Registrar's No.

1. PLACE OF DEATH:

(a) County Maries County.

(b) City or town Rural Route. Salmonie Tu

(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 Missouri (b) County Maries, 63

(c) City or town Vichy, 0

(If outside city or town limits write "RURAL")

(d) Street No. (If rural, give location)

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

3. (a) PRINT FULL NAME Margaret Ann Cruts.

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex Female /

5. Color or race White

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

6. (b) Name of husband or wife William Henry Cruts.

6. (c) Age of husband or wife if alive 86 years

7. Birth date of deceased February 2nd, 1859 (Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
82	10	19	hr. min.

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

10. Usual occupation Housewife.

11. Industry or business "

FATHER
12. Name Mason Mills.
13. Birthplace Illinois. / (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Mary Miller.
15. Birthplace Illinois. / (City, town, or county) (State or foreign country)

16. (a) Informant Claude Cruts.

(b) Address St James, Missouri.

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

(c) Place: burial or cremation Barnole Cemetery.

18. (a) Signature of funeral director Jonas & Gomez

(b) Address St James, Mo.

19. (a) 1/15/42 (Date received local registrar) (b) Chancie Dickson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month December, day 21st, 1941 year 1941 hour 10 minute 15p M.

21. I hereby certify that I attended the deceased from May 31, 1941, to December 21, 1941 that I last saw her alive on December 16, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Cerebral Hemorrhage	
Due to Chronic interstitial Nephritis	1 year
Due to Hypertension	
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 statistically.

131a

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 0

23. Signature C. V. Hammler (M. D. [redacted])

Address St. James, Mo Date signed 12/22/41

(Licensed Embalmer's Statement on Reverse Side)

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.

. S. No. 2B
M—8-21-41
I X29288

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.....

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

1. PLACE OF DEATH:

(a) County: Maries

(b) City or town: Rural Johnson
(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: Mo. (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: Margaret A. Crutso

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: Feb. (Month) 28 (Day) 1859 (Year)

8. AGE: Years 82 Months 10 Days ..... 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 Dec. day 24 year 1941 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....;
that I last saw h... alive on ..... 19.....;
and that death occurred on the date and hour stated above.

Immediate cause of death..... *Duration*

Due to.....

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 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..... (M. D. or other).....
Address..... Date signed.....

SUPPLEMENTARY

11307