DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 4 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11647

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

1. PLACE OF DEATH:
(a) County: Pike
(b) City or town: Clarksville
(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: Pike
(c) City or town: Clarksville
(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.? _____ years.

3. (a) PRINT FULL NAME: Arthur Crow
3. (b) If veteran, name war _____
3. (c) Social Security No. _____

4. Sex: Male
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: /
6. (b) Name of husband or wife: Mabel Edna Crow
6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased: Don't Know (Month) (Day) (Year)

8. AGE: Years: About 83 | Months | Days | If less than one day _____ hr. _____ min.

9. Birthplace: Ashley (City, town, or county) Mo (State or foreign country)
10. Usual occupation: Retired
11. Industry or business: Laborer
FATHER
12. Name: Thorton Reynolds
13. Birthplace: Don't Know (City, town, or county) _____ (State or foreign country)
MOTHER
14. Maiden name: Happett
15. Birthplace: Don't know (City, town, or county) _____ (State or foreign country)
16. (a) Informant's own signature: Edna Mabel Crowe
(b) Address: Frankford Burial
17. (a) (Burial, cremation, removal) (b) Date thereof: Jany 23 (Month) (Day) (Year)
(c) Place: burial or cremation: /
18. (a) Signature of funeral director: Harry L Carroll
(b) Address: Louisiana, Mo
19. (a) _____ (Date received local registrar) (b) _____ (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Jan day: 21 st
year: 1942 hour: 12 minute: 5 A M.
21. I hereby certify that I attended the deceased from Jan 20, 1941, to Jan 21, 1941; that I last saw him alive on Jan. 20, 1942; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	2 days
Due to Arteriosclerosis	Unknown
Due to Age	
Other conditions (Include pregnancy within 3 months of death) /	
Major findings: Of operations / 83	
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: E M Barlea (M. D. ~~or other~~)
Address: Clarksville Mo Date signed 1/23/42

(Licensed Embalmer's Statement on Reverse Side)

Rev. 5-17-39 I X19511

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

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sh[illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very i[illegible]

MAR 13 1959

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 me

, Registered Apprentice No.

working under my personal supervision.

Signed Harry L. Carroll

Licensed Embalmer No. 2439

P. O. Address Clarksville Tn

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.

V. S. No. 2B
10M—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 11647

Registration District No. 685 Primary Registration District No. 4409 Registrar's No.

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

SUPPLEMENTARY

1. PLACE OF DEATH:

(a) County Pike

(b) City or town Clarksville Twn
(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 (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 Arthur Crow

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race C

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 (Month) (Day) (Year)

8. AGE: Years about 83 Months 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) 3/26/42 (Date received local registrar) (b) Florence H. Roberts (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day 21 year 1942 hour 12 minute 5 a.M.

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

	Duration
Immediate cause of death	
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 E. M. Bartlett (M. D. or other)
Address Clarksville, Mo. Date signed 1/22/42

11647