

FILED MAY 13 1942  
Registration District No. 25

Primary Registration District No. 3039

1. PLACE OF DEATH:

(a) County Vernon  
(b) City or town Nevada, R.T.A.  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
Nevada City Hospital  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution two days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

3. (a) PRINT FULL NAME Jack Croner  
(b) If veteran name war r  
(c) Social Security No. None

4. Sex Male 5. Color or race White  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Frances Russell Croner  
6. (c) Age of husband or wife if alive 76 years  
7. Birth date of deceased Jan. 3rd. 1864  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days 3  
If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

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

10. Usual occupation Magnetic Healer

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

12. Name John R. Croner

13. Birthplace Lucas Ohio  
(City, town, or county) (State or foreign country)

14. Maiden name Rebecca Jane Adair

15. Birthplace Lucas Ohio  
(City, town, or county) (State or foreign country)

16. (a) Informant Frank C. Croner

(b) Address Washington Iowa

17. (a) Newton B. Park Date thereof Apr. 8 1942  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newton Burial Park

18. (a) Signature of funeral director Ray Funeral Service

(b) Address Nevada Missouri

19. (a) April 10 1942 (b) Elizabeth Breckenridge  
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Vernon  
(c) City or town Nevada  
(If outside city or town limits, write "RURAL")  
(d) Street No. 510 W. Cherry Street  
(If rural, give location)  
(e) Citizen of foreign country?  (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 6<sup>th</sup>  
year 1942 hour 3 min. \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from Mar. 3/16 to Apr. 4/6 1942; that I last saw him alive on 4/5 1942; and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma of bowels ✓  
Duration \_\_\_\_\_  
Due to Unknown

Due to

Other conditions None  
(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? \_\_\_\_\_

While at work?  (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature J. M. Yates (M. D. or other) \_\_\_\_\_  
Address Nevada Mo Date signed 4/9-42

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

12-31

RECEIVED

District Health Officer No. 7,

District File Number 5-42-471

Date Filed 5-11-42

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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 Allen V. Hayes

Licensed Embalmer No. 1968

P. O. Address Nevada Mo

**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. 15820

Registration District No. 875

Primary Registration District No. 3139

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County Vernon Nevada  
 (b) City or town \_\_\_\_\_  
(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 \_\_\_\_\_ (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

Jacob D. Carone

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 m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased Jan 2 1864  
(Month) (Day) (Year)

8. AGE: Years 78 Months 3 Days \_\_\_\_\_  
(If less than one day min.)

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

10. Usual occupation \_\_\_\_\_

11. Industry of 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)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ day \_\_\_\_\_  
 year 1942 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_  
 that I am a physician and am duly licensed to practice medicine in \_\_\_\_\_, 19\_\_\_\_  
 and that death occurred on the date and hour stated above.  
 Immediate cause of death \_\_\_\_\_

Due to Cancer of bowels  
due to sigmoid

Due to \_\_\_\_\_  
 Other conditions (include pregnancy within 3 months of death) 46 e

Major findings: \_\_\_\_\_  
 Of operations \_\_\_\_\_  
 Of autopsy \_\_\_\_\_

Duration \_\_\_\_\_

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? \_\_\_\_\_

While at work? \_\_\_\_\_  
(Specify type of place) (c) Means of injury

23. Signature J. M. [Signature] (M. D. or other) \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed \_\_\_\_\_

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

SUPPLEMENTARY

1942

S-15820

Handwritten notes, possibly including "1942" and "S-15820".