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

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED AUG 10 1942

Registration District No. 266

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 5371

24226

State File No.

Registrar's No. 52

33 0 0

1. PLACE OF DEATH:

(a) County Dent

(b) City or town Current typ
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: X
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution X (Specify whether years, months or days)

In this community all his life

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Dent

(c) City or town rural
(If outside city or town limits, write "RURAL")

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

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

33 0 0

3. (a) PRINT FULL NAME William Crabtree

3. (b) If veteran, name war X

3. (c) Social Security No. X

4. Sex male

5. Color or race W

6. (a) Single, widowed, married, divorced child

6. (b) Name of husband or wife X

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

7. Birth date of deceased Jan (Month) 21 (Day) 1938 (Year)

8. AGE: Years 4 Months 5 Days 28 If less than one day hr. min.

9. Birthplace Current Typ (City, town, or county) Mo (State or foreign country)

10. Usual occupation X

11. Industry or business X

FATHER 12. Name Nathan Crabtree

13. Birthplace Current typ (City, town, or county) Mo (State or foreign country)

MOTHER 14. Maiden name Martha Lamborn

15. Birthplace Shannon Co (City, town, or county) Mo (State or foreign country)

16. (a) Informant Nathan Crabtree

(b) Address Montauk Mo

17. (a) burial (Burial, cremation, or removal) (b) Date thereof 7/20/42 (Month) (Day) (Year)

(c) Place: burial or cremation Pattersong Cem

18. (a) Signature of funeral director Chas H. Turner

(b) Address Salem Mo

19. (a) 7-20-42 (Date received local registrar) (b) Jas D. McLeod by [illegible] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 19 year 1942 hour 10 minute A M.

21. I hereby certify that I attended the deceased from July 16 1942 to July 19 1942 that I last saw him alive on July 19 1942 and that death occurred on the date and hour stated above.

Immediate cause of death Appendicitis

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) 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? No (Specify type of place)

While at work? (e) Means of injury

23. Signature Leslie Randell (M. D. or other)

Address Licking Mo Date signed 7-20-42

11'17

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No 5,
District File Number 742478
Date Filed 8-6-42

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 ..... Embalming

Licensed Embalmer No. .....

P. O. Address .....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit 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. 24226

Registration District No. 266 Primary Registration District No. 5371 Registrar's No.

1. PLACE OF DEATH:

(a) County: Dent

(b) City or town: Rural
(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: Life

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: William Crabtree

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex: M

5. Color or race: W

6. (a) Single, widowed, married, divorced: S

6. (b) Name of husband or wife

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

7. Birth date of deceased: Jan (Month) 21 (Day) 1938 (Year)

8. AGE: Years 4 Months 5 Days If less than one day hr. min.

9. Birthplace: (City, town, or county) Mo. (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) (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 July 19 Day 19 year 1942 hour minute 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.

Immediate cause of death — Duration

Due to: Ruptured appendix

Due to:

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

12:1

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