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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 11 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 26695

Registration District No. 42 | Primary Registration District No. 1000 | Registrar's No.

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

1. PLACE OF DEATH:
(a) County: Buchanan
(b) City or town: St. Joseph, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Mercy Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution: 3 days (Specify whether years, months or days)
In this community: ~~3 da~~

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Buchanan
(c) City or town: De Kalb (If outside city or town limits, write "RURAL") 0
(d) Street No.: Rural (If rural, give location)
(e) If foreign born, how long in U. S. A.? — years.

3. (a) PRINT FULL NAME: VELMA ARLENE CROCKETT
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: single
6. (b) Name of husband or wife: —
6. (c) Age of husband or wife if alive: — years
7. Birth date of deceased: August (Month) 18th (Day), 1942 (Year)

8. AGE: Years | Months | Days: 3 | If less than one day: hr. min.

9. Birthplace: St. Joseph, Mo. (City, town, or county) 0 (State or foreign country)
10. Usual occupation: —
11. Industry or business: —
FATHER
12. Name: William Oscar Crockett
13. Birthplace: Nicholas Co., Kentucky (City, town, or county) (State or foreign country)
MOTHER
14. Maiden name: Nellie May Stephens
15. Birthplace: Ringgold Co., Iowa (City, town, or county) (State or foreign country)
16. (a) Informant: Mrs. W. O. Crockett
(b) Address: De Kalb, Mo.
17. (a) B. (Burial, cremation, or removal) (b) Date thereof: 8-25-42 (Month) (Day) (Year)
(c) Place: burial or cremation: Ashland
18. (a) Signature of funeral director: FLEEMAN MORTUARY, INC.
(b) Address: St. Joseph
19. (a) 8-25-42 (Date received local registrar) (b) Rose Hogan (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Aug. day: 21st. year: 1942 hour: 6 (a) minute: 30 P.M.
21. I hereby certify that I attended the deceased from ....., 19..., to ....., 19...; that I last saw her alive on Aug. 20th, 1942, and that death occurred on the date and hour stated above.

Immediate cause of death: congenital malformation — 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: E. L. Plath, D.O. (M. D. or other)
Address: De Kalb, Mo. Date signed: Aug 23, 1942

1233 (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, fact should be so stated above.