No. 2
-5-42
-17-39
X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 11 1943

Registration District No. 8

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 103642

Primary Registration District No. 8006

Registrar's No. 89

1. PLACE OF DEATH:
(a) County: Boone
(b) City or town: Columbia
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1216 Walnut St.
(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: 6 Years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Boone
(c) City or town: Columbia
(If outside city or town limits, write "RURAL")
(d) Street No.: 1216 Walnut St.,
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: 0

3. (a) PRINT FULL NAME: JAMES HENRY CROSWHITE

3. (b) If veteran, name war: None

3. (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: Hattie

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

7. Birth date of deceased: 2 (Month) - 17 (Day) - 1858 (Year)

8. AGE: Years 85 | Months 1 | Days 14 | If less than one day ..... hr. ..... min.

9. Birthplace: Randolph County (City, town, or county) Missouri (State or foreign country)

10. Usual occupation: Retired Physician

11. Industry or business:

FATHER
12. Name: William Croswhite
13. Birthplace: Not Known (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Armazenda Holloway
15. Birthplace: Not Known (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs. James H. Croswhite
(b) Address: 1216 Walnut St., Columbia, Mo.

17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 4-4-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Waverly, Missouri

18. (a) Signature of funeral director: Columbia, Mo.
(b) Address:

19. (a) 4-2-'43 (Date received local registrar) (b) Edna H Barber (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month: Apr. day: 1 year: 1943 hour: 7:30 minute: P. M.

21. I hereby certify that I attended the deceased from March 31, 1943, to Apr 1, 1943, that I last saw him alive on Apr 1, 1943, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Bronchial Pneumonia Rt-	2 days
Due to: Bronchial Asthma	years
Due to:	
Other conditions (Include pregnancy within 3 months of death): 10	

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

23. Signature: F. C. Suggett (M. D. or other) M.D.
Address: Columbia Date signed: 4-2-43

12.50

(Licensed Embalmer's Statement on Reverse Side)

MAR 4 1946

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 W. D. Whitsides

Licensed Embalmer No. 3893

P. O. Address Columbia mo

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, fact should be so stated above.

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. 13642

Registration District No. 38 Primary Registration District No. 3006 Registrar's No. 89

1. PLACE OF DEATH:

(a) County Boone

(b) City or town Columbia
(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 6 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Boone

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

(d) Street No. 1216 Walnut St
(If rural, give location)

(e) Citizen of foreign country? ____ (Yes or No)

If yes, name country ____

3. (a) PRINT FULL NAME James H Cross White

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 M

6. (b) Name of husband or wife Hattie 6. (c) Age of husband or wife if alive ____ years

7. Birth date of deceased Feb 17 1858
(Month) (Day) (Year)

8. AGE: Years 85 Months 1 Days 1 If less than one day ____ hr. ____ min.

9. Birthplace Mo.
(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) ____ (b) Date thereof ____
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation ____

18. (a) Signature of funeral director Parkus F. Sunne
(b) Address Columbia Mo

19. (a) ____ (b) ____
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Apr day 1
year 1943 hour 7:30 minute pm 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.

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

SUPPLEMENTARY