

DEPARTMENT OF COMMERCE

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

BUREAU OF THE CENSUS

FILED AUG 12 1948

Registration District No. 200

Primary Registration District No. 5725

Registrar's No. 62

1. PLACE OF DEATH:

(a) County Macon
(b) City or town Rural (Hudson)
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Skell-Hildreth Osteopathic San
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 7 yrs 1 mo
(Specify whether years, months or days) 7 yrs 1 mo 9 da

2. USUAL RESIDENCE OF DECEASED:

(a) State Iowa (b) County Madison
(c) City or town Winterset
(If outside city or town limits, write "RURAL")
(d) Street No. 6th and Court Ave.
(If rural, give location)
(e) Citizen of foreign country? No. (Yes or No)
If yes, name country 2

3. (a) PRINT FULL NAME Mrs Martha A. Crawford

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, Widowed

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

7. Birth date of deceased Nov 18 1859
(Month) (Day) (Year)

8. AGE: Years 83 Months 7 Days 18 If less than one day _____ hr. _____ min.

9. Birthplace Polk County Iowa
(City, town, or county) (State or foreign country)

10. Usual occupation Retired

11. Industry or business _____

12. Name John Blumer Huston

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

14. Maiden name Sally Flint

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

16. (a) Informant L. L. Blumgren Gdn.

(b) Address Winterset, Iowa

17. (a) BURIAL (b) Date thereof 7-9-43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Winterset Cem.

18. (a) Signature of funeral director Neil W. Anderson

(b) Address Winterset, Iowa

19. (a) 8/3/43 (b) Jora Blumgren
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 6th
year 1943 hour 4:5 minute AM.

21. I hereby certify that I attended the deceased from May 27
1936 to July 6 1943
that I last saw h. ea. alive on July 6 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Senile Dementia Duration 12 yr

Due to Chronic Myocarditis + Myocardial degeneration

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? _____

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

Signature F. M. Oll (M. D. or other)
Address Mason Mo Date signed 7-6-48

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

61
0
0

MOTHER FATHER

105

RECEIVED

District Health Officer No. 10

District File Number 8-43-1340

Date Filed AUG 11 1943

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..... Albert Skinner.....

Licensed Embalmer No. 751

P. O. Address Macon Mo

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.