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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

31200

State File No.

FILED SEP 24 1943

Registration District No. 7

Primary Registration District No. 4-0-55133

Registrar's No. 1018

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

1. PLACE OF DEATH:

(a) County Buchanan

(b) City or town Rural R.F.D. No. 1, Easton, Mo.
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution _____ (Specify whether _____)

In this community 60 yrs. years, months or days (Specify whether _____)

3. (a) PRINT FULL NAME FRANK LOGAN CROUSE

3. (b) If veteran, name war no

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 Nazel Crouse

6. (c) Age of husband or wife if alive 56 years

7. Birth date of deceased May 10 1883
(Month) (Day) (Year)

8. AGE: Years 60 Months 4 Days 2 If less than one day _____ hr. _____ min.

9. Birthplace Buchanan Co. Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Farmer

11. Industry or business _____

MOTHER FATHER { 12. Name Mrs. F. Crouse

{ 13. Birthplace Buchanan Co. Mo.
(City, town, or county) (State or foreign country)

{ 14. Maiden name Waller F. Applegate

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

16. (a) Informant Mrs. Nazel Crouse

(b) Address R.F.D. 1 Easton Mo.

17. (a) Burial (b) Date thereof 9/15/43
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Blakesly Cemetery

18. (a) Signature of funeral director F. L. Taylor

(b) Address Stewartville Mo.

19. (a) 9/15/43 (b) Rose Deigo
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Buchanan

(c) City or town R, F, D, No 1, Easton,
(If outside city or town limits write "RURAL")

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

(e) If foreign born, how long in U. S. A.? 0 years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 12th
year 1943 hour One minute 30 M.

21. I hereby certify that I attended the deceased from June 1st
1943 to Sept 12 1943;
that I last saw him alive on Sept 12th 1943
and that death occurred on the date and hour stated above.

Immediate cause of death Mitral Insufficiency Duration _____

Due to Rheumatic Fever in 90

Due to _____

Other conditions none
(Include pregnancy within 3 months of death)

Major findings: Of operations _____

Of autopsy none

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 B. W. Tadlock (M. D. or other) _____
Address St. Joseph, Mo. Date signed 9/15/43

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(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 Donell D. Lyon

Licensed Embalmer No. 3640

P. O. Address Plattsburg 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, above space should be left blank.