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DM-243  
5-17-39  
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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **31285**

Registrar's No. **1073**

FILED OCT 13 1943

Registration District No. **132**

Primary Registration District No. **1000**

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

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

**2. USUAL RESIDENCE OF DECEASED:**  
 (a) State Missouri (b) County Buchanan  
 (c) City or town St. Joseph  
(If outside city or town limits, write "RURAL")  
 (d) Street No. 2124 South 4th St  
(If rural, give location)  
 (e) Citizen of foreign country? no (Yes or No)  
 If yes, name country \_\_\_\_\_

**3. (a) PRINT FULL NAME** Mabel Weil

**3. (b) If veteran, name war** no **3. (c) Social Security No.** \_\_\_\_\_

**4. Sex** Female **5. Color or race** white **6. (a) Single, widowed, married, divorced, widow** divorced widow

**6. (b) Name of husband or wife** Ernest **6. (c) Age of husband or wife if alive** \_\_\_\_\_ years

**7. Birth date of deceased** March 1st 1906  
(Month) (Day) (Year)

<b>8. AGE:</b>	<b>Years</b> <u>37</u>	<b>Months</b> <u>6</u>	<b>Days</b> <u>29</u>	<b>If less than one day</b> _____ hr. _____ min.
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**9. Birthplace** Sheridan, Mo. 0  
(City, town, or county) (State or foreign country)

**10. Usual occupation** Clerk

**11. Industry or business** United Dept Stores

**12. Name** John Russell Crull

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

**14. Maiden name** Ariantha Azalee

**15. Birthplace** Watson, Mo.  
(City, town, or county) (State or foreign country)

**16. (a) Informant** Troy Crull  
**(b) Address** 2124 South 4th St St. Joseph, Mo.

**17. (a) Burial** **(b) Date thereof** 10-4-43  
(Burial, cremation, or removal) (Month) (Day) (Year)

**(c) Place: burial or cremation** Ashland Cemetery

**18. (a) Signature of funeral director** Tracy Barry Funeral  
**(b) Address** 218 South 10th St St. Joseph, Mo.

**MEDICAL CERTIFICATION**

**20. DATE OF DEATH:** Month September Day 30th  
 year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ P.M.

**21. I hereby certify that I attended the deceased from** 9-3-43  
 \_\_\_\_\_, 19\_\_\_\_, to 9-30, 1943  
 that I last saw her alive on 9-30, 1943  
 and that death occurred on the date and hour stated above.

Immediate cause of death: cerebro-hemorrhage  
arterio-sclerosis

Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

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

Major findings: none  
 Of operations \_\_\_\_\_  
 Of autopsy: none

**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? no  
(City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?  
none

**23. Signature** Cliffen South (M. D. or other)  
 Address Welflau Road Date signed 10/1/43

Duration \_\_\_\_\_  
 PHYSICIAN \_\_\_\_\_  
 Underline the cause to which death should be charged statistically.

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**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 *Law Clark*

Licensed Embalmer No. *42160*

P. O. Address *St Joseph R*

**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.**