

ED NOV 8 1943 **128**
Registration District No. **128**

Primary Registration District No. **5465**

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

1. PLACE OF DEATH:

(a) County **GREENE**
(b) City or town **Rural, N. Campbell Twp.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **GREENE CO. HOSPITAL**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **4 DAYS** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **LESTER GRANT CROCKER**

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 **WIDOWER**

6. (b) Name of husband or wife **Unk.** 6. (c) Age of husband or wife if alive **27** years

7. Birth date of deceased: (Month) **Aug** (Day) **27** (Year) **1871**

8. AGE:	Years	Months	Days	If less than one day
	72	1	22	hr. min.

9. Birthplace **Greene Co., Mo.** (City, town, or county) (State or foreign country)

10. Usual occupation **Retired Carpenter**

11. Industry or business **Carpenter**

12. Name **G.R. Crocker**

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

14. Maiden name **Unk. Epps**

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

16. (a) Informant **Marvin G. Crocker**

(b) Address **Springfield, Mo.**

17. (a) **Burial** (Burial, cremation, or removal) (b) Date thereof **Oct 21-1943** (Month) (Day) (Year)

(c) Place: burial or cremation **New Hope Cemetery**

18. (a) Signature of funeral director **G. W. Ingner Co.** (b) Address **Springfield, Mo.**

19. (a) **10-26-43** (Date received local registrar) (b) **Dr. W. H. Haubry** (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **MO** (b) County **GREENE**
(c) City or town **SPRINGFIELD**
(If outside city or town limits, write "RURAL")
(d) Street No. **615-5 Campbell** (If rural, give location)
(e) Citizen of foreign country? **No** (Yes or No)
If yes, name country **0**

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Oct** day **19** year **1943** hour **6** minute **45 A.** M.

21. I hereby certify that I attended the deceased from **Oct 15** 19**43** to **Oct 19** 19**43**
that I last saw him alive on **Oct 16** 19**43**
and that death occurred on the date and hour stated above.

Immediate cause of death: **Myocarditis, Chronic**

Due to _____

Due to _____

Other conditions (Include pregnancy within 3 months of death) **930**

Major findings: Of operations _____

Of autopsy _____

Duration

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) _____
() Means of injury _____

23. Signature **James L. Umack** (M. D. or other) _____
Address **Springfield, Mo.** Date signed **10-17-43**

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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 Roy A. Lavin

Licensed Embalmer No. 1763

P. O. Address Springfield 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.