

MISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No. **37670**

Registration District No. **FILED DEC 9 1943**

Primary Registration District No. **4028**

Registrar's No. **25-**

1. PLACE OF DEATH:

(a) County **Liberal**

(b) City or town **Liberal**  
(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) **1**

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

In this community **30 yrs**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Barton**

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

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country **0**

3. (a) PRINT FULL NAME **JOHN ROBERT CRANK**

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

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

6. (b) Name of husband or wife **Maggie Crank** 6. (c) Age of husband or wife if alive **55** years

7. Birth date of deceased **July 20th, 1879**  
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	<b>64</b>	<b>3</b>	<b>26</b>	_____ hr. _____ min.

9. Birthplace **Shell City Missouri**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Laborer**

11. Industry or business \_\_\_\_\_

MOTHER FATHER

12. Name **George Crank**  
13. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)

14. Maiden name **Hester**  
15. Birthplace **Unknown**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs Maggie Crank**  
(b) Address **Liberal, MO.**

17. (a) **Burial** (b) Date thereof **11-20-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Barton City Cemetery**  
18. (a) Signature of funeral director **River Funeral Home**  
(b) Address **Lamar, MO.**

19. (a) **Nov. 19-1943** (b) **Blancha Sackett**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **16th**  
year **1943** hour **5** minute **45 A.M.**

21. I hereby certify that I attended the deceased from **Nov. 12**  
19**43** to **Nov. 14** 19**43**  
that I last saw him alive on **Nov. 14** 19**43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Drapery**  
Duration **6 mos**

Due to **Nephritis & complications**

Due to **Senility**

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations **None**  
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) **None**

(b) Date of occurrence **None**

(c) Where did injury occur? **None**  
(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. R. Spell** (M. D. or other) \_\_\_\_\_  
Address **Liberal** Date signed **11/17/43**

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

RECEIVED

District Health Officer No. 6,

District File Number 1243-1338

Date Filed DEC 7 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

*E. J. Mann*

Licensed Embalmer No.

3816

P. O. Address

*James M.*

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.

Registration District No. *14*

Primary Registration District No. *4028*

Registrar's No. *20*

1. PLACE OF DEATH:

(a) County *Barton*  
(b) City or town *Liberal*  
(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 \_\_\_\_\_ (Specify whether  
years, months or days) *Cranks*

3. (a) PRINT FULL NAME *John Robert Clark*

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

7. Birth date of deceased *July 20* (Month) (Day) (Year)

8. AGE: Years *64* Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

9. Birthplace \_\_\_\_\_ (City, town, or county) (State or foreign country) *Mo.*

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

12. Name \_\_\_\_\_

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

14. Maiden name \_\_\_\_\_

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

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)  
(Burial, cremation, or removal)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

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

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Nov* Day *6*  
year *1943* hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_ 19\_\_\_\_;  
that I last saw him \_\_\_\_\_ 19\_\_\_\_;  
and that death occurred on the date and hour stated above.  
Immediate cause of death *Cardiac* Duration \_\_\_\_\_

Due to *nephritis & complication*  
*Chronic Alcoholism*

Due to *Senility*

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 \_\_\_\_\_

23. Signature *Frank R. Spell* (M. D. or other) *MD*  
Address *Liberal Mo.* Date signed *Dec 15*

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

SUPPLEMENTARY

MOTHER FATHER

37670