

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

38125

FILED DEC 11, 1943

Registration District No.

Primary Registration District No. 5409

State File No.

Registrar's No.

83

1. PLACE OF DEATH:

- (a) County DOUGLAS
(b) City or town MILLER TWP - RURAL
(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 74 yrs (Specify whether years, months or days)

In this community

3. (a) PRINT FULL NAME

JULIUS R. CRAIN

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,

2 divorced WIDOWED

6. (b) Name of husband or wife

SARAH E. CRAIN

6. (c) Age of husband or wife if

alive 18 years

7. Birth date of deceased

MAY 18

1858

(Month) (Day) (Year)

8. AGE:

Years

Months

Days

If less than one day

85

5

26

hr. min.

9. Birthplace

CARBONDALE

ILLINOIS

(City, town, or county)

(State or foreign country)

10. Usual occupation

FAK M P Y

11. Industry or business

12. Name

GEORGE CRAIN

13. Birthplace

NOT KNOWN

(City, town, or county)

(State or foreign country)

14. Maiden name

NOT KNOWN

15. Birthplace

NOT KNOWN

(City, town, or county)

(State or foreign country)

16. (a) Informant

William CRAIN

(b) Address

R-2 MANSFIELD MO

17. (a) BURIAL

(Burial, cremation, or removal)

(b) Date thereof

NOV 15-43

(Month) (Day) (Year)

(c) Place: burial or cremation

MT EVERETT (C.M.)

18. (a) Signature of funeral director

J. C. Duffe

(b) Address

MANSFIELD MO

19. (a) 12-1-1943

(Date received local registrar)

Mrs. J. R. Spaullock

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State MISSOURI (b) County DOUGLAS
(c) City or town /
(If outside city or town limits, write "RURAL")

(d) Street No. MILLER TWP - RURAL
(If rural, give location)

- (e) Citizen of foreign country? NO (Yes or No)

If yes, name country /

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV day 14
year 1943 hour 12 minute 30 A M.

21. I hereby certify that I attended the deceased from

19..... to 19.....

that I last saw h..... alive on 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death

Toxemia

Due to

Beriberi America

Due to

Other conditions

(Include pregnancy within 3 months of death)

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)

(e) Means of injury

23. Signature

M. C. Gentry

(M. D. or other)

Address

Ans. Mo.

Date signed 11-26-43

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

RECEIVED

District Health Officer No. 6,

District File Number

1243-1348

Date Filed

12-8-43

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, ^{NOT} or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed.....

F.A. Steffe

Licensed Embalmer No.....

3221

P. O. Address.....

Manfield 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.