

No. 2  
-442  
-17-39  
X32873

FILED JAN 20 1944

State File No. ....

Registration District No. 196

Primary Registration District No. 3036

Registrar's No. 152

1. PLACE OF DEATH:

(a) County Lawrence

(b) City or town Aurora  
(If outside city or town limits, write "RURAL" and name of township)

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

(d) Length of stay: In hospital or institution 9 days  
(Specify whether years, months or days)

In this community about 18 years  
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Lawrence

(c) City or town Rural Monett  
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? no (Yes or No)  
If yes, name country: .....

3. (a) PRINT FULL NAME Crystal Agnes Eubanks

3. (b) If veteran, name war: none

3. (c) Social Security No. none

4. Sex F 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Willis W Eubanks 6. (c) Age of husband or wife if alive 37 years

7. Birth date of deceased July 14 1905  
(Month) (Day) (Year)

8. AGE: Years 38 Months 3 Days 21 If less than one day hr. min.

9. Birthplace Union County Kentucky  
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business None

12. Name John William Hazel

13. Birthplace Webster County Kentucky  
(City, town, or county) (State or foreign country)

14. Maiden name George Alva McKee

15. Birthplace Union County Kentucky  
(City, town, or county) (State or foreign country)

16. (a) Informant J.W. Hazel

(b) Address Wheaton Missouri

17. (a) Burial (b) Date thereof 11-11-1943  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 9007 Gene Monett Mo

18. (a) Signature of funeral director Callaway

(b) Address Monett Mo

19. (a) 12-10-1943 (b) C. C. ...  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 8 & 5  
year ..... hour 7 minute 45 P.M.

21. I hereby certify that I attended the deceased from Aug 10  
..... 19 43 to Nov 6 19 43  
and that death occurred on the date and hour stated above.

that I last saw h.c. alive on Nov 8 19 43

Immediate cause of death Ectopic Ectopic

Due to Pregnancy 6 months

Due to .....

Other conditions (Include pregnancy within 3 months of death) .....

Major findings: Of operations .....

Of autopsy .....

Duration 6 days

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) (Specify means of injury) .....

23. Signature Frank Meun MD (M. D. or other) .....

Address Monett Mo Date signed 11/17/43

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

MOTHER FATHER

RECEIVED  
DATE FILED  
144-50  
Date Filed 1-11-47

**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 J. R. Buchanan

Licensed Embalmer No. 3179

P. O. Address Monett 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.**

Registration District No. 115

Primary Registration District No. 2036

Registrar's No. 152

1. PLACE OF DEATH

(a) County Lawrence

(b) City or town Union  
(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

3. (a) PRINT FULL NAME Crystal A. Eubanks

3. (b) If veteran, name war \_\_\_\_\_

3. (c) Social Security No. \_\_\_\_\_

4. Sex F

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 \_\_\_\_\_ year

7. Birth date of deceased July 14 1907  
(Month) (Day) (Year)

8. AGE: Years 28 Months 3 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ min.

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

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

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

MOTHER FATHER { 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 \_\_\_\_\_  
(Burial, cremation, or removal) (Month) (Day) (Year)

(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 Feb day 15  
year 1943 hour \_\_\_\_\_ minute \_\_\_\_\_ M.

21. I hereby certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_; to \_\_\_\_\_, 19\_\_\_\_; and that death occurred on the date and hour stated above.

Immediate cause of death Eclampsia

Due to pregnancy 6 months

Due to Operative delivery performed 4 1/2 hours before death

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

PHYSICIAN \_\_\_\_\_

Major findings:  
Of operations \_\_\_\_\_

Of autopsy 148a

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? \_\_\_\_\_

23. Signature Frank M. M.D. (Specify type of place) \_\_\_\_\_ (M. D. or other) \_\_\_\_\_  
Address Monett Mo Date signed 1/27/44

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

SUPPLEMENTARY

3303