

Registration District No. 374

Primary Registration District No. 6127

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

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Near Lampe, Missouri
(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 all life years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State MO (b) County Stone

(c) City or town Near Lampe, Mo
(If outside city or town limits, write "RURAL")

(d) Street No. Rural Pine Twp
(If rural, give location)

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

3. (a) PRINT FULL NAME Francis Marion Cron

3. (b) If veteran, name war no

3. (c) Social Security No. NO

4. Sex Male

5. Color or race Wh

6. (a) Single, widowed, married, divorced, Widowed

6. (b) Name of husband or wife _____

6. (c) Age of husband or wife if alive _____ years (Day) (Year)

7. Birth date of deceased Feb. 7 1869
(Month) (Day) (Year)

8. AGE:

Years	Months	Days	If less than one day
<u>75</u>	<u>1</u>	<u>10</u>	_____ hr. _____ min.

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

10. Usual occupation Farmer

11. Industry or business _____

12. Name Francis M. Cron

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

14. Maiden name Louisa Jones

15. Birthplace D. K.
(City, town, or county) (State or foreign country)

16. (a) Informant Sam Cron

(b) Address Blue Eye, Mo

17. (a) Burial (b) Date thereof 3/19/44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation McCullough cemetery

18. (a) Signature of funeral director Helson Funeral Home

(b) Address Berwynville Ark.

19. (a) 3-24-44 (b) Chester S. Sewe
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 17
year 1944 hour 8:30 minute _____ P.M.

21. I hereby certify that I attended the deceased from mech 15 1944, to mech 17 1944;
that I last saw him alive on mech 15 1944;
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Hemorrhage
Due to Arterio Sclerosis

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

Major findings: _____
Of operations _____

Of autopsy _____

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 MO

23. Signature L.S. Shumate (M. D. or other) _____
Address Reeds Spring Mo. Date signed 3/20/44

Duration 2 days
PHYSICIAN _____
Underline the cause to which death should be charged statistically.

11/92

RECEIVED

District Health Officer No. 6,

District File Number 444-431

Date Filed APR 11 1944

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.....

me

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

working under my personal supervision.

Signed *Rev L. Nelson*.....

Licensed Embalmer No. *2992*.....

P. O. Address. *Berryville Ark*.....

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.