

FILED MAY 17 1944

Primary Registration District No. 5667

Registrar's No. _____

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

1. PLACE OF DEATH: Lincoln
 (a) County County Farm
 (b) City or town Gray
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution Bedford Farm
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 10 years (Specify whether)
 In this community _____
 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo (b) County Lincoln
 (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 _____

3. (a) PRINT FULL NAME JOE CRUSE
 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, single
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased: July 17, 1857
 (Month) (Day) (Year)

8. AGE: Years 92 Months 26 Days 8 If less than one day _____ hr. _____ min.

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

10. Usual occupation _____

11. Industry or business _____

MOTHER FATHER }
 12. Name Don't Know
 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 Alexander

18. (a) Signature of funeral director Kemp's Funeral Home
 (b) Address Gray, Mo 3.7. Temple

19. (a) April 26 1944 (b) Mo Gray Jackson
 (Day received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3-28 day 25
 year 1944 hour 6 a m minute _____ M.

21. I hereby certify that I attended the deceased from 1932 to 1944
 that I last saw him alive on Mar 16 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Old age and
complications of disease
Especially Influenza
 Duration 1 month

Due to _____
 Due to 33a
 Other conditions _____
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations _____
 Of autopsy _____
 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)
 (c) Means of injury _____
 23. Signature R.A. Hicks (M. D. or other)
 Address Gray Date signed 3-28-44

RECEIVED
District Health Officer, No. 9,
District File Number.....
Date Filed 5-15-44

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.....

Morris Maschany

Licensed Embalmer No. 2461

P. O. Address. Wentzville 7

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. 179 Primary Registration District No. 5667

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

1. PLACE OF DEATH: Lincoln
 (a) County _____
 (b) City or town Rural Bedford Twp
(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 _____
years, months or days

3. (a) PRINT FULL NAME Joe Cruise
 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 S.
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
 7. Birth date of deceased July 17 1908
(Month) (Day) (Year)

8. AGE: Years 92 Months 26 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 Mo (b) County Lincoln
 (c) City or town Rural
(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 _____ day _____
 year _____ hour _____ minute _____ M.
 21. I hereby certify that I attended the deceased from _____ 19____;
 that I last saw him _____ alive on _____ 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

Duration

Due to _____
 Due to _____

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

PHYSICIAN

Major findings:
 Of operations _____
 Of autopsy _____
 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?

(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

18513