

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22640

FILED JUL 12 1944

State File No.

Registration District No.

Primary Registration District No.

Registrar's No.

1. PLACE OF DEATH:

(a) County Saline
(b) City or town Marshall
(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 ARTHUR CROBARKER

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

4. Sex M 5. Color or race Negro 6. (a) Single, widowed, married, divorced Widowed
6. (b) Name of husband or wife Martha Crobarker 6. (c) Age of husband or wife if alive Unknown years
7. Birth date of deceased Unknown
(Month) (Day) (Year)

8. AGE: Years 65 Months 7 Days 9 If less than one day hr. min.

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

10. Usual occupation Farmer

11. Industry or business Farmer

12. Name Sam Crobarker

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

14. Maiden name Martha Sparrow

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

16. (a) Informant Bessie Crawford

(b) Address Marshall Mo

17. (a) Burial (b) Date thereof 6-26-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Funeral Home Saline Co Mo

18. (a) Signature of funeral director F. H. Ferguson

(b) Address Saline Mo

19. (a) 6-26-44 (b) Mrs. C. O. Westlake
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline 97
(c) City or town Marshall Mo 1
(If outside city or town limits, write "RURAL") 2
(d) Street No. none (If rural, give location)
(e) Citizen of foreign country? no (Yes or No)
If yes, name country no

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 6 day 24
year 1944 hour 7:30 minute A M.

21. I hereby certify that I attended the deceased from June 1944 to June 24th, 1944
that I last saw him alive on 6-24, 1944
and that death occurred on the date and hour stated above.

Immediate cause of death Valvular Heart Disease
Duration 1 yr. or more

Due to

Due to

Other conditions (Include pregnancy within 3 months of death) 92d

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?

(Specify type of place) While at work? (e) Means of injury

23. Signature W. H. Madison (M. D. or other)

Address Marshall Mo Date signed 6-26-44

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

MOTHER FATHER

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed

7-11-44

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

F. D. Ferguson

Licensed Embalmer No. 2188

P. O. Address

See below

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.