

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

FILED AUG 18 1944

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

27560

State File No.

Registration District No. 2-1-79

Primary Registration District No. 5-2-9-5301

Registrar's No. 3

1. PLACE OF DEATH:

(a) County Col
(b) City or town Jefferson City, Missouri
(c) Name of hospital or institution:
11 miles west of city on Bonville Rd
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution.....
In this community 73 yrs (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Col 26
(c) City or town Jefferson City 0
(If outside city or town limits, write "RURAL")
(d) Street No. Jefferson
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME James W. McCrez

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

4. Sex M 5. Color or race Wh 6. (a) Single, widowed, divorced, Single

6. (b) Name of husband or wife..... 6. (c) Age of husband or wife if alive..... years

7. Birth date of deceased Sept 18 1870
(Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 26 If less than one day hr. min.

9. Birthplace Colo County (City, town, or county) Mo (State or foreign country)

10. Usual occupation Farmer

11. Industry or business For self

12. Name James W. McCrez

13. Birthplace Colo County (City, town, or county) Mo (State or foreign country)

14. Maiden name Anderson

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

16. (a) Informant Logan Partridge

(b) Address Jefferson City, Mo

17. (a) Buried (Burial, cremation, or removal) (b) Date thereof 8-11-44 (Month) (Day) (Year)

(c) Place: burial or cremation State Cemetery

18. (a) Signature of funeral director Funeral Service

(b) Address 700 Jefferson

19. (a) 8/12/44 (Date received local registrar) (b) J. Wilthaus (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 10th year 1944 hour 8 minute 0 M.

21. I hereby certify that I attended the deceased from Sept 7 1944 to Aug 10 1944 that I last saw him alive on Aug 9 1944 and that death occurred on the date and hour stated above.

Immediate cause of death hypostatic pneumonia Duration 4 days
Due to broken hip 4 mo

Other conditions (Include pregnancy within 3 months of death)
Major findings: **ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED**
Of operations.....
Of autopsy.....
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 1-2-1
(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 Paul J. ... Address ... Date signed 8/12/44

AUG 16 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.....
..... Registered Apprentice No.....
..... working under my personal supervision.

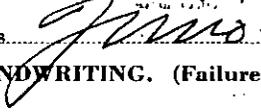
Signed



Licensed Embalmer No.

3641

P. O. Address



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. _____ Primary Registration District No. _____ Registrar's No. _____

1. PLACE OF DEATH:

(a) County Cole
(b) City or town 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 _____ (Specify whether _____)
In this community _____ years, months or days 73 yr.

3. (a) PRINT FULL NAME James W. McCrea

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 5

6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Sept. 18 (Month) (Day) (Year)

8. AGE: Years 73 Months 10 Days 12 (If less than one day) _____ min.

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

10. Usual occupation Farmer

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 _____ (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 Sept year 1944 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ to _____, 19____

that I last saw him alive on _____, 19____, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Hypostatic Pneumonia

Due to Broken Hip

Due to _____

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) Accident? Fall from porch

(b) Date of occurrence Sept. 17, 1944

(c) Where did injury occur? Ypsilanti Township Cole Mo. (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? at home, fall of front porch

While at work? no (Specify type of place) (e) Means of injury fall

23. Signature Carleton W. Griffith, M.D., physician

Address Columbia Mo. Date signed 5/27/44

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SUPPLEMENTARY INFORMATION REQUESTED

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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