

**FILED SEP 8 1944**  
Registration District No. **1944**

Primary Registration District No. **4267**

Registrar's No. **40**

1. PLACE OF DEATH:

(a) County **Lafayette**  
(b) City or town **Odessa**  
(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 **Life**  
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo.** (b) County **Lafayette**  
(c) City or town **Odessa**  
(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 **Elizabeth D. Crouch**

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

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

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

7. Birth date of deceased **June 5, 1864**  
(Month) (Day) (Year)

8. AGE: Years **80** Months **2** Days **20** If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

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

10. Usual occupation **At Home**

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

MOTHER FATHER { 12. Name **Andrew J. Cox**  
13. Birthplace **Missouri**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Ann D. Glower**  
15. Birthplace **Kentucky**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Tom Crouch**  
(b) Address **Odessa, Mo.**

17. (a) **Burial** (b) Date thereof **Aug. 20, 1944**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Odessa, Mo. Cem.**

18. (a) Signature of funeral director **Dr. Heuser**  
(b) Address **Odessa, Mo.**

19. (a) **Sept-2-1944** (b) **Mrs. W. Baker**  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Aug** day **25<sup>th</sup>** year **1944** hour **2** minute **45<sup>0</sup>** M.

21. I hereby certify that I attended the deceased from **Aug 25, 1944** to **Aug 25, 1944** that I last saw him alive on **Aug 25** and that death occurred on the date and hour stated above. Immediate cause of death **Coronary Thrombosis** Duration **1 day**

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Major findings:

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 \_\_\_\_\_  
(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)  
(a) Means of injury \_\_\_\_\_  
23. Signature **R. Schoddy** (M.D. or other) \_\_\_\_\_  
Address **Odessa, Mo.** Date signed **8/31/44**

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

RECEIVED

District Health Officer No. 8,

District File Number

9-7-44

SEP 12 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

*Joseph T. Heuser*

Licensed Embalmer No.

7541

P. O. Address

*Olson, Inc*

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.