

Registration District No. FILED OCT 19 1944

Primary Registration District No. 4426

Registrar's No. 11

1. PLACE OF DEATH:

(a) County Polk

(b) City or town Fair Play
(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) 1

(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 Iso (b) County Polk 24

(c) City or town Fair Play
(If outside city or town limits, write "RURAL") U

(d) Street No. _____ (If rural, give location)

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

3. (a) PRINT FULL NAME Buel A. Crow

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 married

6. (b) Name of ~~deceased~~ wife Madeline Crow 6. (c) Age of ~~deceased~~ or wife if alive 51 years

7. Birth date of deceased Jan II 1892
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day

52 8 14 hr. min.

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

10. Usual occupation Live Stock Dealer

11. Industry or business _____

12. Name J.W. Crow

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

14. Maiden name Sarah G. Akins

15. Birthplace Cedar County, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs Buel A. Crow

(b) Address Fair Play, Mo.

17. (a) Burial (b) Date thereof 9-27-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Akard Cemetary

18. (a) Signature of funeral director Barber, Ewing & Blue

(b) Address Fair Play, Mo.

19. (a) 9-30-1944 (b) Worah In Allister
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 25th
year 1944 hour 12 minute 45 P.M.

21. I hereby certify that I attended the deceased from Sept 13th, 1944, to Sept 25, 1944; that I last saw him alive on Sept 25, 1944; and that death occurred on the date and hour stated above.

Immediate cause of death Coronary occlusion

Due to Angina Pect. Attacks Over Period (known) 2 wks

Due to _____

Other conditions 94a
(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 _____

23. Signature Dr. J. F. Wilson (M. D. or other) Dr
Address Fair Play Mo Date signed 9/29/44

Duration _____

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

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

34
0
C
10/11/44
H. T.

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 *Shepard R. Erwin*

Licensed Embalmer No. *3092*

P. O. Address *Polina, Mo.*

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.