No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 17 1944

Registration District No. 42

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 33804

Primary Registration District No. 2007

Registrar's No. 215

1. PLACE OF DEATH:
(a) County Butler
(b) City or town Poplar Bluff (If outside city or town limits, write "RURAL," and name of township)
(c) Name of hospital or institution: Poplar Bluff Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution X (Specify whether years, months or days)
In this community ~~2 years~~

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Stoddard
(c) City or town Dudley (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Phyllis Ann Crowe
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex FEMALE
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 JUNE (Month) 28 (Day) 1942 (Year)
8. AGE: Years 2 Months 2 Days 29 If less than one day hr. min.
9. Birthplace Dudley (City, town, or county) Mo (State or foreign country)
10. Usual occupation NONE
11. Industry or business
FATHER 12. Name KENNETH CROWE
FATHER 13. Birthplace NOBLE Ill. (City, town, or county) (State or foreign country)
MOTHER 14. Maiden name DOROTHY PARKS
MOTHER 15. Birthplace Dudley (City, town, or county) Mo (State or foreign country)
16. (a) Informant Kenneth Crowe
(b) Address Dudley Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Sept 29, 44 (Month) (Day) (Year)
(c) Place: burial or cremation Dudley Mo
18. (a) Signature of funeral director E. L. Watkins
(b) Address Hayter Mo
19. (a) 9-29-44 (Date received local registrar) (b) Belle Dinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 26 year 1944 hour 7 minute 30 P.M.
21. I hereby certify that I attended the deceased from 9-26, 1944, to 9-26, 1944, that I last saw her alive on 9-26 1944, and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Myelogenous Leukemia	Unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy 74a

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature J. W. Fonda (M. D. ~~coroner~~)
Address Poplar Bluff, Mo. Date signed 9-28-44

92

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 1044-1355
Date Filed 10-11-44

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 Lyman Steele

Licensed Embalmer No. 2476

P. O. Address Dexter 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.

S. No. 2B
1—8-21-41
I X29298

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 41.

Registration District No. 43 Primary Registration District No. 3007 Registrar's No. 315

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

1. PLACE OF DEATH:

(a) County Butler

(b) City or town Poplar Bluff
(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 1 day (Specify whether
In this community years, months or days)

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

3. (a) PRINT FULL NAME Phyllis Ann Crowe

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex

5. Color or race

6. (a) Single, widowed, married, divorced

6. (b) Name of husband or wife

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

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

8. AGE: Years | Months | Days | 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
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director
(b) Address

19. (a) 10/8/44 (Date received local registrar) (b) Belle Kinne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 9 day 26
year 1944 hour minute M.

21. I hereby certify that I attended the deceased from
19 , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
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)
(b) 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

33804