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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 10 1944

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 34634

Registration District No. 181

Primary Registration District No. 4293

Registrar's No. 25

1. PLACE OF DEATH:
 (a) County Lincoln
 (b) City or town Elsbury, Mo.
 (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 (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State Mo. (b) County Linn
 (c) City or town Elsbury, Mo 57
 (If outside city or town limits, write "RURAL")
 (d) Street No. 0 (If rural, give location)
 (e) Citizen of foreign country? 0 (Yes or No)
 If yes, name country 0

3. (a) PRINT FULL NAME MAGGIE M. CRANK
 3. (b) If veteran, name war No
 3. (c) Social Security No. No

MEDICAL CERTIFICATION
 20. DATE OF DEATH: Month Oct day 29
 year 1944 hour 8 minute 15 P. M.
 21. I hereby certify that I attended the deceased from Aug 43 to Oct 29 1944
 that I last saw her alive on Oct 29 1944
 and that death occurred on the date and hour stated above.

4. Sex female 5. Color or race white
 6. (a) Single, widowed, married, divorced married
 6. (b) Name of husband or wife J. W. Crank 6. (c) Age of husband or wife if alive 82 years
 7. Birth date of deceased May 7 1869
 (Month) (Day) (Year)

Immediate cause of death King's Congestive due to metastasis
 Due to Carcinoma of Breast
 Duration 10 mos
 Due to 1 1/2 yrs

8. AGE: Years 75 Months 7 Days 23
 If less than one day hr. min.

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

10. Usual occupation Housewife

11. Industry or business

12. Name J. N. Mitchell

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

14. Maiden name Mattie Lebeck

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

16. (a) Informant Mrs. J. W. Crank

(b) Address Elsbury, Mo

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 10-31-1944 (Month) (Day) (Year)

(c) Place: burial or cremation Elsbury Cemetery

18. (a) Signature of funeral director Elston Mills

(b) Address Elsbury, Mo

19. (a) (Date received local registrar) (b) (Registrar's signature)

Other conditions (Include pregnancy within 3 months of death) 50
 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) (Means of injury)
 23. Signature D. V. Keelney (M. D. or other)
 Address Elsbury, Mo Date signed 10-31-44

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

1193

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RECEIVED

District Health Officer No. 9;

District File Number.....

Date Filed 11-8-44

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 Oct 29-19

....., Registered Apprentice No.....
working under my personal supervision.

Signed Clifton Mills

Licensed Embalmer No. 3364

P. O. Address Elabany, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. na

Registration District No. 181

Primary Registration District No. 4293

Registrar's No. 23

1. PLACE OF DEATH

(a) County Lincoln

(b) City or town Elsherry, mo
(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 Maggie M. Crank

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race w

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

6. (b) Name of husband or wife _____

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

7. Birth date of deceased May 7 1886
(Month) (Day) (Year)

8. AGE: Years 75 Months _____ Days _____ If less than one day _____ min.

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

10. Usual occupation _____

11. Industry or business _____

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 _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) Nov. 6, 1944 (b) S. G. Williams
(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 Oct Year 1944 Day 9 Minute _____ M.

21. I hereby certify that I attended the deceased from _____ 19____; that I last saw him/her alive on _____ 19____; and that death occurred on the date and hour stated above. Immediate cause of death _____

Due to _____

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) _____

(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 _____ (M. D. or other) _____
Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

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

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

34644