

FILED DEC 12 1944

Registration District No. **284**

Primary Registration District No. **3026**

1. PLACE OF DEATH:

(a) County Jackson
(b) City or town Independence
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Independence Sanitarium Hospital
(If not in hospital or institution, write street number or location) 0
(d) Length of stay: In hospital or institution 2 Weeks (Specify whether years, months or days)
In this community 2 Weeks (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Oklahoma (b) County Nowata
(c) City or town Blue Jacket
(If outside city or town limits, write "RURAL")
(d) Street No. R.E.D. #2
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Daisy Dell Crownover

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 Married
6. (b) Name of husband or wife Matt Crownover 6. (c) Age of husband or wife if alive 63 years
7. Birth date of deceased June 20th, 1880
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
64 4 17 hr. min.

9. Birthplace San Antonio, Texas
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business _____

12. Name Andrew Briggs Kuykendall

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

14. Maiden name Mary D. Desmeke

15. Birthplace San Antonio, Texas
(City, town, or county) (State or foreign country)

16. (a) Informant Mr. Matt Crownover

(b) Address Blue Jacket Okla.

17. (a) Removal (b) Date thereof 11-7-44
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Miami, Okla.

18. (a) Signature of funeral director Roland T. Speaks

(b) Address Independence, Mo.

19. (a) 11-7-44 (b) James W. Ross
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 7th
year 1944 hour 6 minute 10 A. M.

21. I hereby certify that I attended the deceased from at 31
1944 to Nov 6, 1944
that I last saw alive on Nov 6
and that death occurred on the date and hour stated above.

Immediate cause of death Acute myocardial infarction Duration 4 yrs
Toxic gastritis
Due to Curcuma of the liver 4 yrs

Other conditions (Include pregnancy within 3 months of death) None

Major findings: Of operations _____ Of autopsy 63 hr

22. If death was due to external causes, fill in the following:
(c) 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) _____ (Specify type of injury) _____

23. Signature John H. Green (M.D. or other) _____
Address Independence Date signed 11-6-44

PHYSICIAN
Underline the cause to which death should be charged statistically.

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

MOTHER FATHER

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 Poland J. Speaks

Licensed Embalmer No. 3604

P. O. Address Indep. Bldg

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.