

S. No. 2  
M-8-43  
5-17-39  
I X37823

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. **40885**  
Registrar's No. **84**

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS  
FILED JAN 4 7 1945  
Registration District No. **4271945**

Primary Registration District No. **4118**

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

1. PLACE OF DEATH  
(a) County **Christian**  
(b) City or town **Sparta Mo.**  
(c) Name of hospital or institution: **Sparta Township**  
(d) Length of stay: **In hospital or institution**  
In this community **most of his life**

2. USUAL RESIDENCE OF DECEASED:  
(a) State **Mo.** (b) County **Christian**  
(c) City or town **Sparta Mo.**  
(d) Street No. **None**  
(e) Citizen of foreign country? **No.**

3. (a) PRINT FULL NAME **William H. Crain**  
(b) If veteran, name war  
(c) Social Security No.

4. Sex **Male** 5. Color or race **W**  
6. (a) Single, widowed, married **Widowed**  
6. (b) Name of husband or wife  
6. (c) Age of husband or wife if alive years

7. Birth date of deceased **March 14 1863**  
(Month) (Day) (Year)

8. AGE: Years **81** Months **7** Days **7**  
If less than one day hr. min.

9. Birthplace **Christian Mo.**

10. Usual occupation **Farmer Retired**

11. Industry or business  
12. Name **A. C. Crain**  
13. Birthplace **Geneseo**

14. Maiden name **Martha Kerney**  
15. Birthplace **Mo.**

16. (a) Informant **Geo. Crain**  
(b) Address **Sparta Mo.**  
17. (a) **Buried** (b) Date thereof **Oct. 23-44**  
(c) Place: burial or cremation **Sparta Cemetery**

18. (a) Signature of funeral director **T. B. Chaffert**  
(b) Address **Clark Mo.**  
19. (a) **12-29-44** (b) **Mrs. S. M. Johnson**

MEDICAL CERTIFICATION  
20. DATE OF DEATH: Month **Oct.** day **21**  
year **1944** hour **2** minute **50 P.M.**  
21. I hereby certify that I attended the deceased from **July**, 1944, to **Oct-21-**, 1944;  
that I last saw him alive on **Oct-20-**, 1944;  
and that death occurred on the date and hour stated above.

Immediate cause of death **Acute Cardiac Dilatation**  
Due to **Chronic Myocarditis**

Other conditions **9-30**  
(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?  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

23. Signature **Dr. Harry H. Wilson** (M. D. or other) **4460**  
Address **Sparta, Mo.** Date signed **12-29-44**

MOTHER FATHER

1258

(Licensed Embalmer's Statement on Reverse Side)

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**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.....

*T. B. Chaffin*

Licensed Embalmer No.....

*2192*

P. O. Address.....

*Ozark, 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.**