

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

Registration District No. **344** Primary Registration District No. **6187** Registrar's No. _____

1. PLACE OF DEATH: *Stone*

(a) County *Stone*

(b) City or town *Near Lampe Mo.*
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: *William's Hosp*
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution *1*
(Specify whether)

In this community _____
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State *Missouri* (b) County *Stone*

(c) City or town *Berryville, Ark 87-1*
(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 *Nelson Butler Crain*

3. (b) If veteran, name war *World War I*

3. (c) Social Security No. *X*

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month *Dec*, day *25*, year *1944*, hour *unknown*, minute _____, M.

21. I hereby certify that I attended the deceased from *at death*, 1944, to _____, 19____; that I last saw him _____ alive on _____, 19____; and that death occurred on the date and hour stated above.

4. Sex *M* 5. Color or race *wh* 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: *Dec* (Month) *25* (Day) *1889* (Year)

Immediate cause of death *aspiration*

Due to *asthma* *10 3/4*

8. AGE: Years *55* Months *0* Days *0* If less than one day _____ hr. _____ min.

Due to _____

Other conditions (Include pregnancy within 3 months of death) *18 2/2*

9. Birthplace *Stone Co Mo.* (City, town, or county) (State or foreign country)

10. Usual occupation *farmer*

Major findings: Of operations _____ Of autopsy *none*

11. Industry or business _____

12. Name *W.M. H. Crain*

13. Birthplace *Lawrence Co Indiana* (City, town, or county) (State or foreign country)

14. Maiden name *Nancy Roach*

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

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) *no*

(b) Date of occurrence *Natural Death*

(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? *Died in our Home*

While at work? _____ (Specify type of place) (e) Means of injury _____

16. (a) Informant *Clifford Blasugami*

(b) Address *Lampe Mo.*

17. (a) *Burial* (Burial, cremation, or removal) (b) Date thereof *1-1-1945* (Month) (Day) (Year)

(c) Place: burial or cremation *McCollough*

18. (a) Signature of funeral director *Nelson Funeral Home*

(b) Address *Berryville Ark*

19. (a) *1-2-1945* (Date received local registrar) (b) *Chester D. Scott* (Registrar's signature)

23. Signature *Everett J. Cheatham* (M. D. or other) *3*

Address *Helena* *9no* Date signed *12/25/44*

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

4
0
0

MOTHER FATHER

1145-

RECEIVED

District Health Officer No. 6,

District File Number 145-48

Date Filed JAN 12 1945

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.....

Licensed Embalmer No.....

P. O. Address.....

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.