

DELAYED

STATE FILE NUMBER

FILED: JAN 21 1988

CERTIFICATE OF DEATH

235051

124

44-042377

REGISTRATION DISTRICT NO. 245

PRIMARY REGISTRATION DISTRICT NO. 4365

REGISTRAR'S NO. 19

DO NOT WRITE
ON THIS STUB

2

4

5A (Type of Units)

7B

7C

8

10

12

14A

15A

15B

15C & E

15D

21A

24A

25

26

26

26

26

26

26

26

26

27

29A-F

29G-ST

29G-CO

29G-CY

TYPE
OR PRINT
IN
PERMANENT
BLACK
INK
FOR
INSTRUCTIONS
SEE
HANDBOOKFILED ON THE BASIS OF A NOTARIZED STATEMENT FROM THE FUNERAL HOME AND A COPY
RECORDS
OF
FUNERAL HOMEVS 300
Rev. 1/78

DECEDENT

IF DEATH
OCCURRED IN
INSTITUTION,
SEE HANDBOOK
REGARDING
COMPLETION OF
RESIDENCE ITEMS

PARENTS

DISPOSITION

CERTIFIER

CAUSE OF
DEATH

DECEDENT-NAME FIRST MIDDLE LAST			SEX	DATE OF DEATH (Mo., Day, Yr.)	
1. NETTIE JANE CREVISTON			2. Female	3. April 3, 1944	
RACE - (e.g., White, Black, American Indian, etc.) (Specify)		AGE - Last Birthday (Yrs.)	UNDER 1 YEAR		DATE OF BIRTH (Mo., Day, Yr.)
4. White		5a. 61	5b. MOS. DAYS		6. May 5, 1882
CITY, TOWN OR LOCATION OF DEATH			HOSPITAL OR OTHER INSTITUTION - Name (If not in either, give street and number)		
7b. Stark City			7c. Residence in Stark City		
STATE OF BIRTH (If not in U.S.A., name country)		CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)		WAS DECEDENT EVER IN U.S. ARMED FORCES?
8. Arkansas		9. U.S.A.	10. Widowed		12. <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
SOCIAL SECURITY NUMBER			USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		KIND OF BUSINESS OR INDUSTRY
13.			14a. House Wife		14b. Own Home
RESIDENCE-STATE		COUNTY	CITY, TOWN OR LOCATION AND ZIP CODE		STREET AND NUMBER
15a. Missouri		15b. Newton	15c. Stark City 64866		15d.
INSIDE CITY LIMITS (Specify Yes or No)		15e.			
FATHER-NAME FIRST MIDDLE LAST			MOTHER-MAIDEN NAME FIRST MIDDLE LAST		
16. Jack White			17. Unknown Ray		
FUNERAL HOME NAME (Type or Print)			MAILING ADDRESS STREET OR R.F.D. NO. CITY OR TOWN STATE ZIP		
18a. Funeral Home			18b. 307 East Main Street, Neosho, Mo. 64850		
BURIAL, CREMATION, REMOVAL, OTHER (Specify) DATE			CEMETERY OR CREMATORY NAME		LOCATION CITY OR TOWN STATE
19a. Burial April 7, 1944			19b. Harvey Cemetery		19c. La Russell, Missouri
FUNERAL SERVICE LICENSEE Or Person Acting As Such (Signature) NUMBER			NAME OF FACILITY		ADDRESS OF FACILITY
20a. <i>Paul J. Freund</i>			20b. Freund-Thompson Chapel		20c. Neosho, Missouri
REGISTRAR			DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)		
21a. (Signature) <i>Paul J. Freund / Pam Braden, Rep.</i>			21b. January 15, 1988		
22a. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) <i>Paul J. Freund</i>			23a. On the basis of examination and investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. (Signature and Title) <i>Pam Braden</i>		
DATE SIGNED (Mo., Day, Yr.)		HOUR OF DEATH		DATE SIGNED (Mo., Day, Yr.)	
22b.		22c. 11:58 P.M.		23b.	
NAME OF ATTENDING PHYSICIAN IF OTHER THAN CERTIFIER (Type or Print)			PRONOUNCED DEAD (Mo., Day, Yr.)		PRONOUNCED DEAD (Hour)
22d.			23d. ON		23e. AT M
NAME AND ADDRESS OF CERTIFIER (PHYSICIAN, MEDICAL EXAMINER OR CORONER) (Type or Print)			MO. LICENSE NO.		IF HOSP OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify)
24a. Dr. Rollins, Granby, Missouri			24b.		25.
26. IMMEDIATE CAUSE (ENTER ONLY ONE CAUSE PER LINE FOR (a), (b), AND (c).)					
PART I					
(a) DUE TO, OR AS A CONSEQUENCE OF					
(b) DUE TO, OR AS A CONSEQUENCE OF					
(c) DUE TO, OR AS A CONSEQUENCE OF					
PART II OTHER SIGNIFICANT CONDITIONS - Conditions contributing to death but not related to cause given in PART I (a)				AUTOPSY (Specify Yes or No)	
27.				28. WAS CASE REFERRED TO MEDICAL EXAMINER OR CORONER (Specify Yes or No)	
ACC., SUICIDE, HOM., UNDET. OR PENDING INVEST. (Specify)		DATE OF INJURY (Mo., Day, Yr.)		HOUR OF INJURY	
29a.		29b.		29c. M 29d.	
DESCRIBE HOW INJURY OCCURRED		LOCATION (STREET OR R.F.D. NO., CITY OR TOWN, COUNTY, STATE)			
29e.		29f.			
INJURY AT WORK (Specify Yes or No)		PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		IF DECEASED WAS FEMALE WAS THERE A PREGNANCY IN LAST 90 DAYS	
29g.		29g.			
30. <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK					

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 _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

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 embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.