No. 2
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v. 5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 5 1945

Registration District No. 323

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 6099

State File No. 7231

Registrar's No. 8

1. PLACE OF DEATH
(a) County: Schuyler
(b) City or town: Rural (Prairie Twnsp) (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 years, months or days)
In this community: 15 Mo

2. USUAL RESIDENCE OF DECEASED:
(a) State: Mo (b) County: Adair
(c) City or town: Trenton (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: Ella Crow

3. (b) If veteran, name war: ✓

3. (c) Social Security No.: ✓

4. Sex: Fe

5. Color or race: W

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Tom Crow

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

7. Birth date of deceased: July (Month) 6 (Day) 1854 (Year)

8. AGE: Years 84 Months 6 Days 12 If less than one day ..... hr. ..... min.

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

10. Usual occupation: Housewife

11. Industry or business: .....

FATHER
12. Name: Curtis Minor
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant: Mrs Nellie Steen
(b) Address: Lancaster, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-20-1945 (Month) (Day) (Year)
(c) Place: burial or cremation: Ft. Madison (Greenlawn)

18. (a) Signature of funeral director: E. E. Hopper
(b) Address: Clarinda

19. (a) Feb. 5 1945 (Date received by local registrar) (b) A. A. Gibelice (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 18th year 1945 hour 3 P.M. minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..., to ..... 19..., that I last saw h..... alive on ..... 19..., and that death occurred on the date and hour stated above.

Immediate cause of death: Died suddenly. Heart arrest. Had no physician since 1942 Dr Carl Lawndow D.O. attended her.

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:
Of autopsy: 75

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

Duration

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

23. Signature: C. W. Adolf D.O. (M.D. or other)
Address: Coroner Schuyler Date signed: Mo.

1278 (Licensed Embalmer's Statement on Reverse Side)

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

Barcode

RECEIVED
District Health Officer No. 10
District File Number 3-45-382
Date Filed MAR 3 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 Not Embalmed, Registered Apprentice No. ....., working under my personal supervision.

Signed Louis E. Hopper

Licensed Embalmer No. 4261

P. O. Address Clarence NY

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.