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DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

17440

State File No. \_\_\_\_\_

FILED MAY 17 1945  
Registration District No. 142

Primary Registration District No. 5704

Registrar's No. \_\_\_\_\_

1. PLACE OF DEATH:

(a) County MCDona'd

(b) City or town Ianagan *Pineville*  
(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) 1

(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether  
In this community 60 Yrs. (Specify whether  
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County MCDona'd <sup>60</sup>

(c) City or town Ianagan <sup>17</sup>  
(If outside city or town limits, write "RURAL")

(d) Street No. \_\_\_\_\_ (If rural, give location)

(e) Citizen of foreign country? No <sup>0</sup> (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

3. (a) PRINT FULL NAME Orin Crosby

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married

6. (b) Name of husband or wife Minnie Crosby 6. (c) Age of husband or wife if alive 63 years

7. Birth date of deceased June 14th, 1877  
(Month) (Day) (Year)

20. DATE OF DEATH: Month April day 6th,  
year 1945 hour 11 minute 55, P. M.

21. I hereby certify that I attended the deceased from May 1  
1945 to May 6 1946

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 19\_\_\_\_;  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral hemorrhage

Duration \_\_\_\_\_

8. AGE: Years Months Days If less than one day

67 10 8 \_\_\_\_\_ hr. \_\_\_\_\_ min.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

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

Other conditions (Include pregnancy within 3 months of death) \_\_\_\_\_

10. Usual occupation Farming

Major findings: Of operations \_\_\_\_\_

11. Industry or business \_\_\_\_\_

Of autopsy \_\_\_\_\_

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

12. Name Cortez Crosby

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

14. Maiden name Liza Miller

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

16. (a) Informant Minnie Crosby

(b) Address Ianagan MO.

17. (a) Burial (b) Date thereof 4 - 9th, 1945  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Newbethe' Cemetry

18. (a) Signature of funeral director Chas. W. Williams

(b) Address Goodman MO.

19. (a) \_\_\_\_\_ (b) \_\_\_\_\_  
(Date received local registrar) (Registrar's signature)

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? \_\_\_\_\_

While at work \_\_\_\_\_ (Specify type of place) (e) Means of injury \_\_\_\_\_

23. Signature S. B. [unclear] (M. D. or other) \_\_\_\_\_

Address Carleton MO Date signed 4-10-46

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

MOTHER FATHER

**RECEIVED**

District Health Officer No. 6,

District File Number 545-585-

Date Filed MAY 15 1945

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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.....

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.**

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. June  
Registrar's No. 11

Registration District No. 195 Primary Registration District No. 5704

1. PLACE OF DEATH:

(a) County Mc Donald  
(b) City or town Lanezan Anderson  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: Pineville  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_ (Specify whether \_\_\_\_\_)  
In this community \_\_\_\_\_ years, months or days (Specify whether \_\_\_\_\_)

3. (a) PRINT FULL NAME Duicrosby

3. (b) If veteran, name war \_\_\_\_\_ 3. (c) Social Security No. 4

4. Sex m 5. Color or race w 6. (a) Single, widowed, married, divorced m

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if alive \_\_\_\_\_

7. Birth date of deceased June (Month) 1 (Day) 1961 (Year)

8. AGE: Years 67 Months 10 Days \_\_\_\_\_ If less than one day hr. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace \_\_\_\_\_ (City, town, or county) Kansas (State or foreign country)

10. Usual occupation \_\_\_\_\_

11. Industry or business \_\_\_\_\_

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_ (City, town, or county) \_\_\_\_\_ (State or foreign country)

16. (a) Informant \_\_\_\_\_

(b) Address \_\_\_\_\_

17. (a) \_\_\_\_\_ (Burial, cremation, or removal) (b) Date thereof \_\_\_\_\_ (Month) (Day) (Year)

(c) Place: burial or cremation \_\_\_\_\_

18. (a) Signature of funeral director \_\_\_\_\_

(b) Address \_\_\_\_\_

19. (a) June 6 (b) Duicrosby (If not received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State \_\_\_\_\_ (b) County \_\_\_\_\_  
(c) City or town \_\_\_\_\_ (If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
If yes, name country \_\_\_\_\_

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month \_\_\_\_\_ year 1961 hour \_\_\_\_\_ minute \_\_\_\_\_ M. \_\_\_\_\_

21. I hereby certify that I attended the deceased from \_\_\_\_\_ to \_\_\_\_\_, 19\_\_\_\_; that I had saw h. \_\_\_\_\_ alive on \_\_\_\_\_ and that death occurred on the date and hour stated above. \_\_\_\_\_ immediate cause of death \_\_\_\_\_

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_ (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? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

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

23. Signature \_\_\_\_\_ (M. D. or other) \_\_\_\_\_

Address \_\_\_\_\_ Date signed \_\_\_\_\_

SUPPLEMENTARY

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

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