

FILED JUL 16 1945

State File No.

Registration District No.

Primary Registration District No. 3000

Registrar's No. 154

1. PLACE OF DEATH:

(a) County Adair
Kirkville, Mo.

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

(c) Name of hospital or institution:
Grim-Smith Hospital & Clinic 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 5 days
(Specify whether years, months or days)

In this community 5 days
(Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Schuyler 98

(c) City or town Lancaster 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 1 (Yes or No)
If yes, name country.....

3. (a) PRINT FULL NAME Polly Anna Crump

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

20. DATE OF DEATH: Month June day 17th
year 1945 hour 6 minute 20 a.m.
June 12, 1945

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

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

7. Birth date of deceased June 12, 1945
(Month) (Day) (Year)

21. I hereby certify that I attended the deceased from....., 19....., to June 17, 1945, 19.....
that I last saw h or alive on June 16, 1945, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death Pneumonia

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

Duration 3 days

Due to.....

Due to.....

9. Birthplace Kirkville, Mo. - Adair County
(City, town, or county) (State or foreign country)

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

10. Usual occupation.....

11. Industry or business.....

12. Name Boyd Hollis Crump

13. Birthplace Lancaster Mo. 0
(City, town, or county) (State or foreign country)

14. Maiden name Barbara Ann Smith

15. Birthplace New York 1
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Boyd Hollis Crump

(b) Address Lancaster, Mo.

17. (a) Burial (b) Date thereof June 17-45
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation 0

18. (a) Signature of funeral director P. O. Fenton

(b) Address Lancaster, Mo.

19. (a) 6-19-45 (b) Mrs. J. W. Wagner
(Date received local registrar) (Registrar's signature)

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 [Signature] (M. D. or other)

Address Dunsmuir, Nev. Date signed 6-17-45

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

RECEIVED

District Health Officer No. 10

District File Number 7-45-1156

Date Filed JUL 13 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.....
F. O. Fenton

Licensed Embalmer No. 3705

P. O. Address Farmington

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. Aug
Registrar's No. 2548

Registration District No. 1

Primary Registration District No. 3000

1. PLACE OF DEATH:

(a) County Adair

(b) City or town Kershawville
(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 _____ (Specify whether
years, months or days)

3. (a) PRINT FULL NAME Polley A. Crump

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex F

5. Color or race W

6. (a) Single, widowed, married, divorced S

6. (b) Name of husband or wife _____

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

7. Birth date of deceased June 12 1944
(Month) (Day) (Year)

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

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

10. Usual occupation _____

11. Industry or business _____

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) _____ (b) Date thereof _____
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation _____

18. (a) Signature of funeral director _____

(b) Address _____

19. (a) _____ (b) _____
(Date 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 July Day 17
Year 1944 Hour _____ minute _____ M.

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

Due to Pneumonia
Bronchial

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 Blanchard (M. D. or other) _____

Date signed 7-17-44

Duration 3 days

PHYSICIAN _____

Underline the cause to which death should be charged statistically.

SUPPLEMENTARY

ADDITIONAL
SUPPLEMENTARY
INFORMATION
REQUESTED

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

S-23316