

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSTHE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED JUL 30 1945

Primary Registration District No. 5115

Registrar's No. 5115 13

1. PLACE OF DEATH:

(a) County Bollinger
 (b) City or town Rural whitewater
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution:
Sedgewickville Mo RFD 1
 (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)

3. (a) PRINT FULL NAME Andrew Crites

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

4. Sex MO 5. Color or race W 6. (a) Single, widowed, married,
 divorced Married
 6. (b) Name of husband or wife Lora Bollinger Crites 6. (c) Age of husband or wife if
 alive _____ years
 7. Birth date of deceased Feb 9 1879
 (Month) (Day) (Year)

8. AGE: Years 65 Months 9 Days 11 If less than one day
 hr. _____ min. _____

9. Birthplace Cape Girardeau (City, town, or county) (State or foreign country) MO

10. Usual occupation Farmer

11. Industry or business _____

12. Name David Crites
 13. Birthplace Cape Girardeau (City, town, or county) (State or foreign country) MO
 14. Maiden name Lillian Kriebler
 15. Birthplace Missouri (City, town, or county) (State or foreign country) MO

16. (a) Informant Mrs Andrew Crites(b) Address Sedgewickville Mo RFD

17. (a) Burial (b) Date thereof Nov 22 1944
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Post Oak Cemetery18. (a) Signature of funeral director McComb & Co(b) Address Jackson Mo19. (a) July 25 1945 (b) Mrs Geneva Graham

(Date received local registrar)

(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Bollinger
 (c) City or town Rural
 (If outside city or town limits, write "RURAL")
 (d) Street No. Sedgewickville RFD 1
 (If rural, give location)
 (e) Citizen of foreign country? No (Yes or No)
 If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 20
 year 1944 hour 2 minute A M.

21. I hereby certify that I attended the deceased from Jan 1st 1943 to Nov 20th 1944
 that I last saw him alive on Nov 19th 1944
 and that death occurred on the date and hour stated above.

Immediate cause of death Myocarditis
 Due to _____
 Due to _____

Other conditions
 (Include pregnancy within 3 months of death)

Major findings:
 Of operations 93

Of autopsy _____

PHYSICIAN

Underline
 the cause to
 which death
 should be
 charged sta-
 tistically.

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 Edw. Crites (M. D. number) _____Address Sedgewickville Date signed 11/22/44

b63 (Licensed Embalmer's Statement on Reverse Side)

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

AUG 9 1946

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.