S. No. 2
M—5-42
v. 5-17-39
I X32873

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 25 1945

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Dr. Fitch

State File No. 30541

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 712

1. PLACE OF DEATH:

(a) County Greene

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

(c) Name of hospital or institution: St. John's Hosp. (If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 1 Day (Specify whether

In this community 35 Years years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Greene 39

(c) City or town Springfield 2 (If outside city or town limits, write "RURAL")

(d) Street No. 740 S. Weller 6 (If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Ralph A. Crover

3. (b) If veteran, name war No

3. (c) Social Security No. UNK.

4. Sex Male

5. Color or race White

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

6. (b) Name of husband or wife Edna Mae Crover

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

7. Birth date of deceased Aug. (Month) 8 (Day) 1883 (Year)

8. AGE: Years 62 Months 0 Days 28 If less than one day hr. min.

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

10. Usual occupation Billiard Parlor Operator

11. Industry or business

FATHER
12. Name Andrew Crover
13. Birthplace UNK. (City, town, or county) Italy 5 (State or foreign country)

MOTHER
14. Maiden name Columbia UNK.
15. Birthplace UNK. (City, town, or county) Italy 5 (State or foreign country)

16. (a) Informant Mrs. Ralph A. Crover

(b) Address Springfield, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 9/10/45 (Month) (Day) (Year)

(c) Place: burial or cremation St. Mary

18. (a) Signature of funeral director H.H. Lohmeyer

(b) Address Springfield, Mo.

19. (a) 9-10-45 (Date received local registrar) (b) Dr W E Handley (Registrar's signature)

984

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept. day 6 year 1945 hour 4:00 minute p. M.

21. I hereby certify that I attended the deceased from 9-5, 1945, to 9-6, 1945, that I last saw him alive on 9-6, 1945, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Hemorrhage	36 hr.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

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 0

23. Signature [signature] (M. D. or other) MD

Address Springfield, Mo. Date signed 9-7-45

(Licensed Embalmer's Statement on Reverse Side)

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 L. Dooley Gorman

Licensed Embalmer No. 3177

P. O. Address Springfield

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.