No. 2
-8-43
17-39
X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED SEP 20 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 30946

Registration District No. 200 Primary Registration District No. 5'728 Registrar's No. 89

1. PLACE OF DEATH:
(a) County Macon
(b) City or town Round Grove Twp
(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

2. USUAL RESIDENCE OF DEACESED:
(a) State Mo (b) County Macon 61
(c) City or town R R
(If outside city or town limits, write "RURAL")
(d) Street No. 0
(If rural, give location) 0
(e) Citizen of foreign country? no (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Mary Crossing
3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 12 - 1855 (Month) (Day) (Year)

8. AGE: Years	Months	Days	If less than one day
90	1	22	hr. min.

9. Birthplace (City, town, or county) Wisconsin (State or foreign country)
10. Usual occupation Home keeper
11. Industry or business
MOTHER FATHER
12. Name John Crossing
13. Birthplace (City, town, or county) Scotland (State or foreign country)
14. Maiden name Margaret Dellin
15. Birthplace (City, town, or county) Ireland (State or foreign country)
16. (a) Informant Mrs Ed Warner
(b) Address R R Macon Mo
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Aug 6-45 (Month) (Day) (Year)
(c) Place: burial or cremation Bethlehem
18. (a) Signature of funeral director Delmar Skeen
(b) Address Macon Mo
19. (a) 9/4/45 (Date received local registrar) (b) Nora B. Winkler (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 4th year 1945 hour 8:00 minute a M.
21. I hereby certify that I attended the deceased from July 5th 1945 to August 4, 1945 that I last saw he alive on August 4, 1945 and that death occurred on the date and hour stated above.

Immediate cause of death: Sub-dermal hemorrhage right upper chest
Due to: Fracture neck of femur bone
Due to: a fall in home
Duration: 5 weeks

Other conditions (Include pregnancy within 3 months of death)

Major findings: Of operations
Of autopsy

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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

22. If death was due to external causes, fill in the following: 1/61
(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 Leslie Carroll (M.D. or other) M.D.
Address Macon Mo Date signed 8/4/45

1057

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 9-45-1438
Date Filed SEP 17 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 Albert S Kinman

Licensed Embalmer No. 75-1

P. O. Address Macon Mo

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.**

No. 2B
M—3-45
I X43880

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. Oct

Registration District No. 200 Primary Registration District No. 5728 Registrar's No. 89

1. PLACE OF DEATH:

(a) County Macon

(b) City or town Round Grove Twp

(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

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

3. (a) PRINT FULL NAME Mary Cressing

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 (Month) (Day) (Year)

8. AGE: Years 90 Months 1 Days If less than one day hr. min.

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

10. Usual occupation

11. Industry or business

FATHER

12. Name

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

MOTHER

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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct Day 27 year 1945 hour minute M.

21. I hereby certify that I attended the deceased from , 19 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 — Duration

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) Fractured neck

(b) Date of occurrence Oct 27 1945

(c) Where did injury occur? Fractured hip in home (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? In her home in the night (Specify type of place)

While at work? no (e) Means of injury Fell over bed

23. Signature Lloyd Carroll M.D. or other

Address Macon Mo Date signed

SUPPLEMENTARY

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

30946