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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 8 1945

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

34032

State File No. _____

Registration District No. 164

Primary Registration District No. 3032

Registrar's No. 102

1. PLACE OF DEATH:

(a) County Johnson.

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

(c) Name of hospital or institution:
Warrensburg Clinic
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 36 hrs.
(Specify whether

In this community... 36hrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Johnson 57

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

(d) Street No. Warrensburg Clinic. 2
(If rural, give location) 0

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

If yes, name country _____

3. (a) PRINT FULL NAME JIMMEY RAY CRAIN

3. (b) If veteran, name war no

3. (c) Social Security No. NO

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 18
year 1945 hour 9 A.M. minute _____ M.

4. Sex Male 5. Color or race white

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

6. (b) Name of husband or wife none

6. (c) Age of husband or wife if alive, years 16, 1945 (Year)

7. Birth date of deceased OCT. (Month) 16 (Day) 1945 (Year)

21. I hereby certify that I attended the deceased from Oct 16, 1945 to Oct 18, 1945; that I last saw him alive on Oct 18 and that death occurred on the date and hour stated above.

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

Years	Months	Days	If less than one day
		<u>1</u>	<u>12</u> hr. _____ min.

Immediate cause of death Aspiration Pneumonia Duration 20 hrs.

Due to Prematurity

Due to 6 months

9. Birthplace Warrensburg. MO. 0
(City, town, or county) (State or foreign country)

10. Usual occupation none

11. Industry or business _____

MOTHER FATHER { 12. Name Reynolds Crain.

13. Birthplace Switz City. Ind 1
(City, town, or county) (State or foreign country)

14. Maiden name Ruth Wright.

15. Birthplace unknown. Ark. 1
(City, town, or county) (State or foreign country)

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings: Of operations 159

Of autopsy _____

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

16. (a) Informant Reynolds Crain.

(b) Address Lamonte. Mo.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

17. (a) burial (b) Date thereof 10/19/45
(Burial, cremation, or removal) (Month) (Day) (Year)

(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? _____

(c) Place: burial or cremation Sunset Hill Cem.

18. (a) Signature of funeral director Sweeney Phillips.

(b) Address Warrensburg. MO.

While at work? _____
(Specify type of place)

(e) Means of injury ⊙

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

23. Signature [Signature] (M. D. or other) _____
Address [Signature] Date signed 10/19/45

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

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.....

R. A. Phillips
2320

Licensed Embalmer No.....

P. O. Address.....

Warrensburg, 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.

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1102
Registrar's No. 102

Registration District No. 164 Primary Registration District No. 3032

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

1. PLACE OF DEATH:

(a) County Johnson

(b) City or town Warrensburg
(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 _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Jimmy R. Crain

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex m 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 Oct 16
(Month) (Day) (Year)

8. AGE: Years _____ Months _____ Days _____ If less than one day _____ 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) Oct. 19, 1945 (b) Savannah Certificate
(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 Oct day _____
year 1945 hour _____ minute _____ M.

21. I hereby certify that I attended the deceased from _____ 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)

PHYSICIAN _____

Major findings:
Of operations _____

Of autopsy _____

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

Signature _____ (M. D. or other) _____
Address _____ Date signed _____

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