

STANDARD CERTIFICATE OF DEATH

State File No. _____

FILED DEC 15 1945
Registration District No. 157

Primary Registration District No. 55 85

Registrar's No. 274

1. PLACE OF DEATH:

Jasper
(a) County rural - Madison Twnshp
(b) City or town (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Carthage Route 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 65 years
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

Missouri Jasper 49
(a) State (b) County
(c) City or town rural
(If outside city or town limits, write "RURAL")
(d) Street No. Carthage Route 1
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Jesse Franklin Crum

3. (b) If veteran, none name war
3. (c) Social Security No. none

4. Sex male 0
5. Color or race white
6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Luvada Black Crum
6. (c) Age of husband or wife if alive 61 years

7. Birth date of deceased October 3 1880
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	65	1	25	hr. min.

9. Birthplace Jasper County Missouri (City, town, or county) (State or foreign country)

10. Usual occupation farmer

11. Industry or business -----

MOTHER FATHER

12. Name Lewis Crum

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

14. Maiden name Clementine Crum

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

16. (a) Informant Mrs. J. F. Crum
(b) Address Route 1, Carthage, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec 2, 1945 (Month) (Day) (Year)

(c) Place: burial or cremation Park Cemetery

18. (a) Signature of funeral director Knell Mortuary
(b) Address Carthage, Mo.

19. (a) 11-30-45 (Date received local registrar) (b) L. B. Clinton M.D. (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 28
year 1945 hour 9 minute P 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: Cardiac Failure
Chronic Myocarditis
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?

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

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

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

43

1945 8

45-11-936

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.....

Frank W. Kiehl Jr

Registered Apprentice No. 379

working under my personal supervision.

Signed *Emm L. Knell*

Licensed Embalmer No. 391

P. O. Address *Carthage*

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.