No. 2
—8-43
5-17-39
I X37823

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED DEC 29 1945

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 42669

Registration District No. 345 Primary Registration District No. 6162 Registrar's No.

1. PLACE OF DEATH:

(a) County Stone
(b) City or town Reeds Springs, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Ruth M
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community about 75 yrs
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Stone 104
(c) City or town Reeds Spring 0
(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 John B McCrary

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M O

5. Color or race wh

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

6. (b) Name of husband or wife Mary Jane McCrary

6. (c) Age of husband or wife if alive 77 years

7. Birth date of deceased Sept (Month) 4 (Day) 45 (Year)

8. AGE: Years 78 Months 10 Days 9 If less than one day hr. min.

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

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Enoch McCrary
13. Birthplace (City, town, or county) Tenn (State or foreign country)

MOTHER
14. Maiden name Martha Smith
15. Birthplace Tenn (City, town, or county) (State or foreign country)

16. (a) Informant Fate McCrary
(b) Address Reeds Springs

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 7 (Month) 18 (Day) 45 (Year)
(c) Place: burial or cremation Yacum Pon

18. (a) Signature of funeral director Everett J. Cheatham
(b) Address Galena, Mo.

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

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month July day 13
year 1945 hour 8 minute P M.

21. I hereby certify that I attended the deceased from Jan 1943 to July 10 1945
that I last saw him alive on July 10 1945
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Acute Dilation of Hart	?
Due to Pelegra & Chronic Bronchitis	18
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

95

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

23. Signature W. P. Cottrell (M. D. or other)
Address Reeds Springs, Date signed 7-21-45

1604 (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 Everett J. Cheatham

Licensed Embalmer No. 3870

P. O. Address Salem 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.

S. No. 2B
5M—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. Jan

Registration District No. 345 Primary Registration District No. 6162 Registrar's No.

1. PLACE OF DEATH:

(a) County Stone

(b) City or town Reeds Spring Ruth 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 John B. Mc Crary

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 M

6. (b) Name of husband or wife

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

7. Birth date of deceased Sept 4 1864 (Month) (Day) (Year)

8. AGE: Years 78 Months 4 Days 4 If less than one day hr. min.

9. Birthplace (City, town, or county) Mo (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) Dec 2-1945 (Date received local registrar) (b) Mrs Myrtle Wampler (Registrar's signature)

MEDICAL CERTIFICATION

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

21. I hereby certify that I attended the deceased from , 19 , to , 19 ; that I last saw h 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)
(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 (M. D. or other)
Address Date signed

SUPPLEMENTARY

42669