

No. 2
8-43
17-39
X37823

FILED MAY 16 1946

Registration District No. 5777 Primary Registration District No. 5777 Registrar's No. 1-46

1. PLACE OF DEATH:

(a) County Miller

(b) City or town Union *rural*

(c) Name of hospital or institution: _____
Quality

(d) Length of stay: In hospital or institution _____
In this community 1 1/2 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Miller 66

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

(d) Street No. rural Rt. 1 (If rural, give location)

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

If yes, name country _____

3. (a) PRINT FULL NAME WINSTON Lee CRANE

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex M.D. 5. Color or race _____ 6. (a) Single, widowed, married, divorced _____

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

7. Birth date of deceased: 4-6-46
(Month) (Day) (Year)

8. AGE: Years _____ Months 1 1/2 Days _____ If less than one day hr. _____ min. _____

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

10. Usual occupation _____

11. Industry or business _____

12. Name Freddie Lee Crane

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

14. Maiden name Jessie Jeffries

15. Birthplace Kaiser, Mo.
(City, town, or county) (State or foreign country)

16. (a) Informant Freddie Lee Crane

(b) Address Union, Mo.

17. (a) Lat Cemetery (b) Date thereof 4-8-46
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Lat Cemetery

18. (a) Signature of funeral director Orval Crane

(b) Address Union, Mo.

19. (a) April 8, 1946 (b) Mrs. Richard L. Wright
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 7 year 1946 hour 8 minute 45 P. M.

21. I hereby certify that I attended the deceased from April 6 to April 7, 1946, that I last saw him alive on April 6, 1946, and that death occurred on the date and hour stated above.

Immediate cause of death: Jaundered, Toxemia. Duration 1 day

Due to Probably B. H. Factor Mathews blood.

Due to _____

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

Major findings: Of operations _____

Of autopsy _____

1610

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? _____ (c) Means of injury 2

23. Signature M. E. Humphrey (M. D. or other) D.O.

Address Union, Mo. Date signed 4-10-46

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

MOTHER FATHER

RECEIVED
District Health Officer No. 9,
District File Number.....
Date Filed 5-14-46

Body was not embalmed.

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.....

Licensed Embalmer No.....

P. O. Address.....

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.