

No. 5-42
5-17-39
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

22380

FILED JUL 9 1946

State File No.

Registration District No. 324

Primary Registration District No. 3072

Registrar's No. 111

1. PLACE OF DEATH:

(a) County Saline Mo
(b) City or town Marshall Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 568 S. Cedar
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community Lifetime years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Saline Mo
(c) City or town Marshall
(If outside city or town limits, write "RURAL")
(d) Street No. 568 S. Cedar
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country None

3. (a) PRINT FULL NAME Stepleton Crutchfield

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex Male 5. Color or race Negre 6. (a) Single, widowed, married, divorced W

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

7. Birth date of deceased Aug 17 1876
(Month) (Day) (Year)

8. AGE: Years 69 Months 10 Days 6 If less than one day hr. min.

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

10. Usual occupation Labourer

11. Industry or business Labouring

12. Name Wilson Crutchfield

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

14. Maiden name Cherlette Elizabeth Wells

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

16. (a) Informant Mr. Charles Crutchfield

(b) Address 568 S. Cedar Marshall Mo

17. (a) Burial (b) Date thereof 6-25-46
(Burial, cremation, or other) (Month) (Day) (Year)

(c) Place: burial or cremation Marshall, Mo

18. (a) Signature of funeral director Green T. ...

(b) Address Marshall Mo

19. (a) 6-29-46 (b) Mrs. T. O. Westhook
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month June day 22nd
40 year 40 hour 40 minute 0 P. M.

21. I hereby certify that I attended the deceased from June 21 1946 to June 22 1946
that I last saw him alive on June 21 1946
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral Vascular Disease

Due to Chr. Hypertension

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

Major findings: Of operations _____
Of autopsy None

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) NO
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 0

23. Signature Rodriguez (M. D. or other) _____
Address Marshall Mo Date signed 6-29-46

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

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

MOTHER FATHER

294

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 2-8-46

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 Geop. Green

Licensed Embalmer No. 4220

P. O. Address Muskegon, Mich

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.