DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 22447

FILED JUL 1 1946

Registration District No. 3 4 2

Primary Registration District No. 6154

Registrar's No.

1. PLACE OF DEATH:
(a) County Stoddard
(b) City or town Parma Mo R1.
(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)

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo (b) County Stoddard
(c) City or town Parma Mo R1.
(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 Sylvester Cross

3. (b) If veteran, name war ✓

3. (c) Social Security No. ✓

4. Sex M

5. Color or race C

6. (a) ~~Single, widowed~~, married, ~~divorced~~ 1

6. (b) Name of ~~husband~~ or wife Emma Cross

6. (c) Age of husband or wife if alive 40 years

7. Birth date of deceased 1899 (Month) Dec (Day) 23 (Year)

8. AGE: Years 47 | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace Tennessee (City, town, or county) 1 (State or foreign country)

10. Usual occupation Farmer

11. Industry or business Farmer

FATHER
12. Name L. Cross
13. Birthplace Tenn (City, town, or county) 1 (State or foreign country)

MOTHER
14. Maiden name
15. Birthplace Do not Know (City, town, or county) 1 (State or foreign country)

16. (a) Informant Emma Cross
(b) Address Parma R1.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof June 2 46 (Month) (Day) (Year)
(c) Place: burial or cremation

18. (a) Signature of funeral director Dexter Mo
(b) Address

19. (a) June 25 (Date received local registrar) (b) Kate Hawley (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 27 year ..... hour 1946 minute ..... M.

21. I hereby certify that I attended the deceased from May 3 1946 to May 27 1946 that I last saw him alive on May 7 19..; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Mitral mitral	
Due to Regurgitation Regurgitation	
Due to Nephritis	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations ✓	
Of autopsy	

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

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 [signature] (M. D. Another)
Address Ernest Mo Date signed May 31

356 (Licensed Embalmer's Statement on Reverse Side)

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

JUL 2 1946

RECEIVED
District Health Office No. 2
District File Number 6-46-22
Date Filed 6-26-46

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.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. July

Registration District No. 343 Primary Registration District No. 6154 Registrar's No. 0

1. PLACE OF DEATH:

(a) County Stoddard

(b) City or town Rural (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 DEACEASED:

(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 Lyenta Cross

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race C

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 Dec 23 1898 (Month) (Day) (Year)

8. AGE: Years 46 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) Tenn (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) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May 27 Day year 1946 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 Acute —

Due to unknown

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

Major findings: Of operations 130

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

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

22447