

**FILED** SEP 10 1946

Registration District No. 316

Primary Registration District No. 6075

Registrar's No. 251

1. PLACE OF DEATH:

(a) County St. Francois  
(b) City or town R. St. Francois  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 3  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution \_\_\_\_\_  
In this community Forty Eight Years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County St. Francois  
(c) City or town Farmington, Mo.  
(If outside city or town limits, write "RURAL")  
(d) Street No. \_\_\_\_\_ (If rural, give location)  
(e) Citizen of foreign country? No. (Yes or No)  
If yes, name country \_\_\_\_\_

3. (a) PRINT FULL NAME Della Crabdree

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

4. Sex F / 5. Color or race W 6. (a) Single, widowed, married, divorced W 2

6. (b) Name of husband or wife John Crabdree 6. (c) Age of husband or wife if alive \_\_\_\_\_ years

7. Birth date of deceased July 15/41872  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
74 25 hr. min.

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

10. Usual occupation Home maker

11. Industry or business \_\_\_\_\_

12. Name Ed. Noltkamper 4

13. Birthplace Germany (State or foreign country)

14. Maiden name Isna Rose Hoff (State or foreign country)

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

16. (a) Informant Henry Elliott Crabdree

(b) Address Farmington, Mo.

17. (a) D (b) Date thereof 8-12-46  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Glenda, Mo.

18. (a) Signature of funeral director C. H. Cozean

(b) Address Farmington, Missouri

19. (a) 8-12-46 (b) Ethel Rudloff  
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug. 10 day, 1946  
year \_\_\_\_\_ hour 11:30 minute 30 A M.

21. I hereby certify that I attended the deceased from Aug 3 1946 to Aug 10 1946  
that I last saw her alive on Aug 9 1946  
and that death occurred on the date and hour stated above.

Immediate cause of death Cerebral apoplexy Duration \_\_\_\_\_

Due to My perforation

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 type of place) (e) Means of injury 0

23. Signature C. H. Cozean (M. D. or other) MD  
Address 715 S. Olive MO Date signed 8-12-46

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

MOTHER FATHER

RECEIVED

District Health Officer No. 4

District File Number 946-25

Date Filed 9-9-46

SEP 11 1946

**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 *A. Cozen*  
Licensed Embalmer No. 4084  
P. O. Address Farmington, N.H.

**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.**