No. 2
—5-43
5-17-39
I X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED OCT 8 1946

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31071

Registration District No. 255

Primary Registration District No. 5-8-734387

Registrar's No.

1. PLACE OF DEATH:

(a) County Oregon

(b) City or town Alton
(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 Lifetime
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Oregon 75

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

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? 0 (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME W. E. Crews

3. (b) If veteran, name war World War I

3. (c) Social Security No. --

4. Sex Male 0

5. Color or race White

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

6. (b) Name of husband or wife Leona P. Crews

6. (c) Age of husband or wife if alive 49 years

7. Birth date of deceased September (Month) 22 (Day) 1893 (Year)

8. AGE:

Years	Months	Days	If less than one day
52	11	2	hr. min.

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

10. Usual occupation Farming

11. Industry or business Livestock

FATHER
12. Name Benjamin Crews
13. Birthplace Unknown (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name Eliza Custer
15. Birthplace (City, town, or county) Missouri 9 (State or foreign country)

16. (a) Informant Mrs. Leona P. Crews
(b) Address Alton, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 8/27/46 (Month) (Day) (Year)
(c) Place: burial or cremation Shiloh Cem.

18. (a) Signature of funeral director Leland Carter
(b) Address Thayer, Missouri

19. (a) 7-19-46 (Date received local registrar) (b) Mrs W C Johnson (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month August day 24
year 1946 hour 2 minute 00 A. M.

21. I hereby certify that I attended the deceased from after I was Caled to view the Body to 19
that I last saw him alive on A few days Before Death 19
and that death occurred on the date and hour stated above.

Immediate cause of death Heart trouble Short time Died in Bed at Home above stated

Due to Work & Worry is my Opinion

Due to Worry Over Brother in Hospital

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

95C

Duration

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 0

23. Signature G B F Orest (M. D. or other)

Address Alton Mo Date signed 9/18/46

'233 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 5,
District File Number 104654 5
Date Filed 10-7-46

JUL 1 1947

OCT 11 1949

OCT 17 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.....

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.