

Registration District No. **276**

Primary Registration District No. ~~XXXX~~ **5947**

Registrar's No. **29**

1. PLACE OF DEATH:

(a) County **Phelps**
(b) City or town **St James** **trwp**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
Soldiers Home Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **9 months**
(Specify whether
In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Phelps** **81**
(c) City or town **St James** **3**
(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

Etta L Crossan

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 **wid. I**
6. (b) Name of husband or wife **Harry Crossan** 6. (c) Age of husband or wife if alive **dead** years
7. Birth date of deceased **7-15-1886**
(Month) (Day) (Year)

8. AGE: Years **60** Months **4** Days **27** If less than one day
hr. _____ min. _____

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

10. Usual occupation **Home wife**

11. Industry or business **✓**

12. Name **James Lynch**

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

14. Maiden name **Lowell Poe**

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

16. (a) Informant **Gladys Henderson**

(b) Address **Mountain Home Ark**

17. (a) **Remove** (b) Date thereof **9-13-46**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Missouri City Mo**

18. (a) Signature of funeral director **W. H. Richler**

(b) Address **St James Mo**

19. (a) **Sept. 12, 46** (b) **Caro E. Birmingham**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **12**
year **1946** hour **3:10** minute **0** M.
21. I hereby certify that I attended the deceased from **Dec 1945**
19 **Sept 12** to **Sept 12** 19 **46**
that I last saw her alive on **Sept 11** 19 **46**
and that death occurred on the date and hour stated above.

Immediate cause of death **Cardiac Decompensation**
Rheumatic fever
Due to _____ **3 mo**

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

Major findings:
Of operations _____
Of autopsy _____

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 _____
23. Signature **William H. Brewer** (M. D. or other) **MD**
Address **St James** Date signed **9-12-46**

Duration
3 da
3 mo
PHYSICIAN
Underline the cause to which death should be charged statistically.

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

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.