

S. No. 2
1-9-43
5-17-39
X37823

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED DEC 24 1946
Registration District No. 8

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 40047
Registrar's No. 17

Primary Registration District No. 5319

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

1. PLACE OF DEATH:
(a) County COOPER
(b) City or town CLIFTON CITY
(c) Name of hospital or institution: Otterville Twp.
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community LIFE
years, months or days

2. USUAL RESIDENCE OF DECEASED:
(a) State MISSOURI (b) County COOPER
(c) City or town CLIFTON CITY
(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 GEORGE W CROFT
(b) If veteran, name war _____ (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month DEC, day 7, year 1946 hour 5 minute 30 P.M.
21. I hereby certify that I attended the deceased from Jan 1 - 46 to Dec 7, 1946
that I last saw him alive on 12-7, 1946 and that death occurred on the date and hour stated above.

4. Sex MALE 5. Color or race WHITE
6. (a) Single, widowed, married, divorced WID
6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased JAN 7 1863
(Month) (Day) (Year)

Immediate cause of death
Arterio Myocarditis Duration 8 yrs
Due to Asterio sclerosis 12/7
Due to _____
Other conditions (Include pregnancy within 3 months of death)
Major findings: Of operations _____
Of autopsy 93D

8. AGE: Years Months Days If less than one day
83 11 0 hr. _____ min.
9. Birthplace COOPER CO. MO
(City, town, or county) (State or foreign country)
10. Usual occupation NONE

MOTHER FATHER
11. Industry or business _____
12. Name GEORGE CROFT
13. Birthplace ENGLAND
(City, town, or county) (State or foreign country)
14. Maiden name UNKNOWN
15. Birthplace UNKNOWN
(City, town, or county) (State or foreign country)

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

16. (a) Informant GEO. CROFT
(b) Address CLIFTON CITY, MO
17. (a) BURIAL (b) Date thereof 12-10-46
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation NEW LEBANON
18. (a) Signature of funeral director Geo Hilliard
(b) Address Sedalia
19. (a) 12-10-46 (b) Nellie Mullett
(Date received local registrar) (Registrar's signature)

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 Poppy Fogle (M. D. or other) MD
Address Hellsville Date signed 12-9-46

RECEIVED

District Health Officer No. 8,

District File Number.....

Date Filed 12-21-46

MAR 28 1958

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 L. T. Parker

Licensed Embalmer No. 3840

P. O. Address: Salina Mo

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.