U. S. No. 2
00M—2-43
Rev. 5-17-39
I X35697

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAR 21 1947

Registration District No. 398

STATE BOARD OF HEALTH OF MISSOURI
# STANDARD CERTIFICATE OF DEATH

State File No. 12125

Primary Registration District No. 6148

Registrar's No.

**1. PLACE OF DEATH:**
(a) County Stoddard
(b) City or town Bloomfield, Rural
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: None
(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 Years

**2. USUAL RESIDENCE OF DECEASED:**
(a) State Missouri (b) County Stoddard 108
(c) City or town Bloomfield Rural 0
(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 GEORGE A. CRAIN
3. (b) If veteran, name war --
3. (c) Social Security No. ****
4. Sex Female 0
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Evelyn Crane
6. (c) Age of husband or wife if alive -- years
7. Birth date of deceased April (Month) 11, (Day) 1868 (Year)

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 10 | 14 | ____ hr. ____ min. |

9. Birthplace Williamson Co. (City, town, or county) Illinois (State or foreign country) 1
10. Usual occupation Farmer
11. Industry or business
FATHER
12. Name Thomas M. Crain
13. Birthplace ____ (City, town, or county) Ill. (State or foreign country) 1
MOTHER
14. Maiden name Syrena Back
15. Birthplace ____ (City, town, or county) Ill. (State or foreign country) 1
16. (a) Informant Mrs. Edd Sifford
(b) Address Bloomfield, Mo.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 2-26-47 (Month) (Day) (Year)
(c) Place: burial or cremation Bloomfield, Mo.
18. (a) Signature of funeral director Chiles Und. Co.
(b) Address Bloomfield, Mo.
19. (a) 3-14-1947 (Date received local registrar) (b) Rae Webster (Registrar's signature)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Month Feb. day 25th year 1947 hour 12:10 minute A. M.
21. I hereby certify that I attended the deceased from 1-25, 1947, to 2-25, 1947 that I last saw him alive on 2-25, 1947 and that death occurred on the date and hour stated above.

| | Duration |
|---|---|
| Immediate cause of death: CHRONIC MYOCARDITIS | |
| Due to | |
| Due to | |
| Other conditions (Include pregnancy within 3 months of death): ARTERIOSCLEROSIS | |
| ACUTE NEPHRITIS | |

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? (Specify type of place)
While at work? (e) Means of injury
23. Signature [illegible] (M. D. or other)
Address BLOOMFIELD Date signed 2-3-47

355 (Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Office No. 2,
District File Number 342-366
Date Filed 3-12-47

**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 Juan B. Cooper

Licensed Embalmer No. 4119

P. O. Address Bloomfield, 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.**