

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

12288

State File No. _____

FILED MAR 24 1947

Registration District No. 374

Primary Registration District No. 4546

Registrar's No. 17

1. PLACE OF DEATH:

(a) County Worth
(b) City or town Denver, Mo
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 1
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution none
(Specify whether years, months or days) 25 yrs

3. (a) PRINT FULL NAME DORA MAY McCrary

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

4. Sex 7 / 1 5. Color or race W
6. (b) Name of husband or wife Salomon M. Crary 6. (c) Age of husband or wife if alive _____ years
7. Birth date of deceased May 12 1874
(Month) (Day) (Year)

8. AGE: Years 72 Months 9 Days 23 If less than one day hr. _____ min. _____

9. Birthplace Clinton Co Mo
(City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name George T. Lockier
13. Birthplace Jackson Co Mo
(City, town, or county) (State or foreign country)
14. Maiden name Mary A. Davis
15. Birthplace Jackson Co Mo
(City, town, or county) (State or foreign country)

16. (a) Informant Mabel Jones

(b) Address 3109 Sycamore Ave City Mo

17. (a) Burial (b) Date thereof May 7 1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Kent Cemetery

18. (a) Signature of funeral director Bram Bros

(b) Address Denver Mo

19. (a) March 8-47 (b) Leta E. Dawson
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Worth
(c) City or town Denver 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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 3 day 5
year 1947 hour 16 minute 30 A.M.

21. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____;
that I last saw him _____ alive on _____, 19____;
and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral thrombosis instant

Due to _____

Due to _____

Other conditions age
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy 94A

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) (c) Means of injury 3

23. Signature Arch C. S. S. S. (M.D. or other) etc

Address Denver City Date signed 3-5-47

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

345

(Licensed Embalmer's Statement on Reverse Side)

**DISTRICT HEALTH OFFICE
Cameron, Mo,**

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.....

J. P. Brown

Licensed Embalmer No. 2947

P. O. Address. Denver, 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.