S. No. 2
M—5-43
. 5-17-39
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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED MAY 1 ~~1947~~

Registration District No. 53

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 12688

Primary Registration District No. 3010

Registrar's No. 137

1. PLACE OF DEATH:

(a) County Cape Girardeau

(b) City or town Cape Girardeau
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: St. Francis Hospital 0
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 3 days (Specify whether years, months or days)

In this community 3 days

2. USUAL RESIDENCE OF DECEASED:

(a) State Illinois (b) County Alexander 999

(c) City or town Thebes 11
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country? No (Yes or No) 2

If yes, name country

3. (a) PRINT FULL NAME Susan K. Crain

3. (b) If veteran, name war No

3. (c) Social Security No. None

4. Sex Female 1

5. Color or race White

6. (a) Single, widowed, married, divorced Single 0

6. (b) Name of husband or wife

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

7. Birth date of deceased April (Month) 19th (Day) 1947 (Year)

8. AGE: Years	Months	Days	If less than one day
0	0	3	hr. min.

9. Birthplace Cape Girardeau (City, town, or county) Missouri (State or foreign country) 6

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name Don't Know
13. Birthplace Don't Know (City, town, or county) (State or foreign country) 9

MOTHER
14. Maiden name Stella Mae Crain
15. Birthplace Madison (City, town, or county) Illinois (State or foreign country) 1

16. (a) Informant Stella Mae Crain

(b) Address Thebes, Illinois

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-23-1947 (Month) (Day) (Year)

(c) Place: burial or cremation Rose Hill Cemt. Thebes, Ill.

18. (a) Signature of funeral director Ebb Haman

(b) Address Cape Girardeau, Missouri.

19. (a) 4-23-1947 (Date received local registrar) (b) C. C. Summers (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 22nd year 1947 hour 10 minute P. M.

21. I hereby certify that I attended the deceased from April 19, 1947, to April 22, 1947, that I last saw her alive on April 22, 1947, and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cerebral Concussion	4 days.
Due to: Difficult Delivery. 4/19/47	
Due to:	
Other conditions (Include pregnancy within 3 months of death): Congenital Heart Disease.	4 days.

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? (c) Means of injury 0

23. Signature N. J. Oehler (M. D. or other)

Address Cape Girardeau, Mo. Date signed 4-23-47

(Licensed Embalmer's Statement on Reverse Side)

FILED

District Health Officer No. 4

District File Number 447-580

Date Filed 4-28-47

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.....

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.