

FILED OCT 28 1947

Registration District No. **313**

Primary Registration District No. **4458**

Registrar's No. **6**

1. PLACE OF DEATH:

(a) County **St. Clair**
(b) City or town **Collins**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **/**

(If not in hospital or institution, write street number or location)

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

In this community years, months or days

3. (a) PRINT FULL NAME **J. Glen Mc Cracken**

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

4. Sex **male** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **married**

6. (b) Name of husband or wife **Mary Mc Cracken** 6. (c) Age of husband or wife if alive **72** years

7. Birth date of deceased **June 15 1873**
(Month) (Day) (Year)

8. AGE: Years **74** Months **4** Days **2** If less than one day hr. min.

9. Birthplace **Lawrence County Missouri**
(City, town, or county) (State or foreign country)

10. Usual occupation **Teaching**

11. Industry or business

MOTHER FATHER { 12. Name **Joseph C. McCracken** 9
13. Birthplace **unknown**
14. Maiden name **Nancy Crutsinger** (State or foreign country)
15. Birthplace **Tennessee** (City, town, or county) (State or foreign country)

16. (a) Informant **Mary McCracken**
(b) Address **Collins Missouri**
17. (a) **burial** (Burial, cremation, or removal) (b) Date thereof **10-19-47**
(Month) (Day) (Year)

(c) Place: burial or cremation **Robinson Cemetery**
18. (a) Signature of funeral director **Osceola Funeral Home**
(b) Address **Osceola Missouri**

19. (a) **10-20-47** (Date received local registrar) (b) **Catherine Clifford** (Registrar's signature) **1947**

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Clair** **93**
(c) City or town **Collins**
(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 **October** day **17**
year **1947** hour **2** minute **15** A.M.

21. I hereby certify that I attended the deceased from **May 11**
1946 to **Oct 17** 1947.
that I last saw him alive on **Oct 17** 1947;
and that death occurred on the date and hour stated above.

Immediate cause of death **chronic prostatitis** Duration

Due to
Due to

Other conditions **chronic prostatitis**
(Include pregnancy within 3 months of death)

Major findings: Of operations **937**
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?

While at work? (Specify type of place) (e) Means of injury **2**

23. Signature **D. E. D. Brown** (M. D. or other) **Do**
Address **Collins Mo** Date signed **10-19-47**

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

RECEIVED
District Health Officer No. 7
9-47-1275
10-27-47

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 AB Goodrich

Licensed Embalmer No. 3038

P. O. Address Ossola 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.