

S. No. 2
M-5-43
5-17-39
X34671

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **37237**

FILED DEC 3 1947

Registration District No. **5144**

Registrar's No. **404**

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

1. PLACE OF DEATH:

(a) County **Butler**

(b) City or town **Rural, Fisk**
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution **St. Francis Hosp. Butler, Mo.**
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution **1**
(Specify whether years, months or days)

3. (a) PRINT FULL NAME **Sarah Crain,**

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **F** Color or race **W**

6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife _____

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

7. Birth date of deceased **Dec 21 1869**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	78	10	12	hr. _____ min. _____

9. Birthplace **Carterville Ill.**
(City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business **House Work,**

MOTHER FATHER

12. Name **George Crawler**

13. Birthplace **England**
(City, town, or county) (State or foreign country)

14. Maiden name **Mary Buringes,**

15. Birthplace **Carterville Ill.**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Crain,**

(b) Address **Fisk Missouri,**

17. (a) **Burial**
(Burial, cremation, or removal)

(b) Date thereof **11 6 1947**
(Month) (Day) (Year)

(c) Place: burial or cremation **Rombaur Missouri,**

18. (a) Signature of funeral director **Watkins Service**

(b) Address **Puxico Missouri**

19. (a) **11-24-47**
(Date received local registrar)

(b) **R. H. Munter**
(Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **Butler**

(c) City or town **Fisk Rural St Francis T.S.**
(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 _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **November** day **3rd**
year **1947** hour **11** minute **20** P. M.

21. I hereby certify that I attended the deceased from **Oct 15**
19**47**, to **Nov 1** 19**47**
that I last saw her alive on **Nov 1** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death **Myocardial Cerebral Hemorrhage**

Due to _____

Due to _____

Other conditions **83A**
(Include pregnancy within 3 months of death)

Major findings: _____

Of operations: _____

Of autopsy: _____

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 **J. B. Silling**
(M.D. or other)

Address **Fisk Mo** Date signed **Nov 24/47**

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Office No. 2,

District File Number 1347-1578

Date Filed 12-1-47

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 Lynn Steele
Licensed Embalmer No. 2476
P. O. Address Hexter Dr

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.