

S. No. 2
-12-45
5-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

37446

State File No. _____

FILED DEC 4 1947

Registration District No. 71

Primary Registration District No. 3012

Registrar's No. 182

1. PLACE OF DEATH:

(a) County Clay

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

(c) Name of hospital or institution:
302 Foley Street
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____ (Specify whether _____)
In this community Lifetime
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Clay 24

(c) City or town Excelsior Springs 1
(If outside city or town limits, write "RURAL")

(d) Street No. 302 Foley Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)
If yes, name country 0

3. (a) PRINT FULL NAME MATTIE A. McCROSKE

3. (b) If veteran, name war No

3. (c) Social Security No. None

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month NOV. day 24
year 1947 hour 5:00 minute P M.

21. I hereby certify that I attended the deceased from Nov. 19
1947 to Nov. 24, 1947

that I last saw h. er alive on Nov. 20, 1947
and that death occurred on the date and hour stated above.

4. Sex Female 5. Color or race White

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

6. (b) Name of husband or wife John McCroskie

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

7. Birth date of deceased April 15 1864
(Month) (Day) (Year)

Immediate cause of death Coronary Thrombosis Duration _____

8. AGE: Years Months Days If less than one day

83 7 9 hr. _____ min.

Due to hypertension

Due to _____

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

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

10. Usual occupation Housewife

11. Industry or business At home

12. Name Thomas Belt

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

14. Maiden name Wade Bone

15. Birthplace Missouri
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Bernard Alnutt

(b) Address Excelsior Springs, Mo.

17. (a) Burial (b) Date thereof 11/26/1947
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Old Union - Ray County

18. (a) Signature of funeral director Claude Richard

(b) Address Excelsior Springs, Mo.

19. (a) 11/26/47 (b) Caroline Huthung
(Date received local registrar) (Registrar's signature)

Major findings: 44P

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? Y

23. Signature SR M. Craden (Specify type of place) _____ (c) Means of injury 0

(M. D. or other) M. D.

Address Excelsior Springs, Mo Date signed 11/25/47

(Licensed Embalmer's Statement on Reverse Side)

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

MOTHER FATHER

RECEIVED

District Health Officer No. 8,

District File Number _____

Date Filed 12-3-47

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. 4168

P. O. Address Lex Springs, 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.