

FILED NOV 20 1947

Registration District No. _____

Primary Registration District No. 4138

Registrar's No. 75

1. PLACE OF DEATH:

(a) County CLINTON
(b) City or town LATHROP
(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 _____ (Specify whether

In this community 52 years. years, months or days)

3. (a) PRINT FULL NAME Nina Clemmens Cross

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

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, widowed, married, divorced MARRIED

6. (b) Name of husband or wife CROSS T. GROSS 6. (c) Age of husband or wife if alive 41 years

7. Birth date of deceased JAN 28 1899 (Month) (Day) (Year)

8. AGE: Years 68 Months 9 Days 16 If less than one day hr. min.

9. Birthplace KIDVILLE KENTUCKY (City, town, or county) (State or foreign country)

10. Usual occupation HOUSEWIFE

11. Industry or business Home

12. Name Hugh T. Peel

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

14. Maiden name ELLA F. HULLETTE

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

16. (a) Informant Cross T. Cross

(b) Address LATHROP MO.

17. (a) BURIAL (b) Date thereof Nov. 16, 1947 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation LATHROP MO

18. (a) Signature of funeral director DEMOS CRUNK

(b) Address CAMERON, MO

19. (a) Nov. 22, 1947 (b) Winifred W. Moser (Date received local registrar) (Registrar's signature)

(c) 290

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County CLINTON

(c) City or town LATHROP (If outside city or town limits write "RURAL.")

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

(e) If foreign born, how long in U. S. A.? NO years

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov day 14 year 1947 hour 5:00AM minute _____ M.

21. I hereby certify that I attended the deceased from May 17, 1944, to Nov. 13, 1947, that I last saw her alive on Nov 13, 1947, and that death occurred on the date and hour stated above.

Immediate cause of death _____

Cerebral Hemorrhage

Due to _____

Due to _____

Other conditions (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 _____

28. Signature Henry W. King (M. D. or other) DD

Address LATHROP MO Date signed 11/14/47

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

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

25
22
0

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.....

Harold Lee Walker

Registered Apprentice No. *21*

working under my personal supervision.

Signed

Lee Mrs Brunk

Licensed Embalmer No. *2533*

P. O. Address *Cameron, 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, above space should be left blank.