

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED NOV 28 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **38828**

Registration District No. **180**

Primary Registration District No. **4290**

Registrar's No. **50**

1. PLACE OF DEATH:

(a) County **LINCOLN**
(b) City or town **FOLEY**
(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 _____ (Specify whether)
In this community _____ years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **MISSOURI** (b) County **LINCOLN 57**
(c) City or town **FOLEY**
(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 _____

3. (a) PRINT FULL NAME

ANNA BEE CROPPER

3. (b) If veteran, name war _____

3. (c) Social Security No. _____

4. Sex **FEMALE** 5. Color or race **WHITE** 6. (a) Single, widowed, married, divorced **WIDOWED**
7. Birth date of deceased **MAY 12 1863**
(Month) (Day) (Year)

8. AGE: Years **84** Months **6** Days **4** If less than one day hr. min.

9. Birthplace **BOWLING GREEN KY. 1**
(City, town, or county) (State or foreign country)

10. Usual occupation **HOUSEWIFE**

11. Industry or business **OWN HOME**

MOTHER FATHER { 12. Name **JAMES TAYLOR**
13. Birthplace **KY 1**
(City, town, or county) (State or foreign country)
14. Maiden name **ANN FLOYD**
15. Birthplace **KY, 1**
(City, town, or county) (State or foreign country)

16. (a) Informant **CHESTER CROPPER**
(b) Address **TROY, MO.**

17. (a) **BURIAL** (b) Date thereof **NOV 18 1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **TROY, MO.**

18. (a) Signature of funeral director **Wm. H. ...**
(b) Address **Troy, Mo.**
19. (a) **11-18-47** (b) **J. C. ...**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Nov** day **16**
year **1947** hour **9** minute **A.M.**
21. I hereby certify that I attended the deceased from **Aug 10** to **11-16** 19**47**
that I last saw her alive on **11-16** 19**47**
and that death occurred on the date and hour stated above.

Immediate cause of death: **myocardial infarction**
Due to **arterial sclerosis**
Due to **old heart age**

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

Major findings: _____
Of operations: _____
Of autopsy: _____

Duration _____
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 _____
23. Signature **J. C. ...** (M. D. or _____)
Address **Old ...** Date signed **MA**

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

Date: 11-26-47

District Health Officer No.

District Health Officer No.

RECEIVED

0

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..... Joseph J. Marsh

Licensed Embalmer No. 3932

P. O. Address..... Troy, 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.