

S. No. 2
1-1/47
5-17-39

FILED JAN 22 1948
Registration District No. **2918**

Primary Registration District No. **5735**

Registrar's No.

1. PLACE OF DEATH:

(a) County Macon Co. Mo

(b) City or town Macon Co. Mo
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital John E. Brown Sup. 1
(If not in hospital or institution, write street number or location)

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

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Macon

(c) City or town Rural
(If outside city or town limits, write "RURAL")

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

(e) Citizen of foreign country?.....
If yes, name country.....

3. (a) PRINT FULL NAME Orva Krawel

3. (b) If veteran, name war.....

3. (c) Social Security No.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 31
year 1947 hour 5 minute 30 P. M.

21. I hereby certify that I attended the deceased from.....
to.....
that I last saw him..... alive on.....
and that death occurred on the date and hour stated above.

Immediate cause of death Drowned

4. Sex M.D. 5. Color or race W 6. (a) Single, widowed, married, divorced married

6. (b) Name of husband or wife Emma Krawel 6. (c) Age of husband or wife if alive 36 years

7. Birth date of deceased July 19, 1888
(Month) (Day) (Year)

Due to driving started up side down in ditch having

Due to about 4 ft of water

Other conditions slipping at time

(Include pregnancy within 3 months of death)

8. AGE: Years 39 Months 5 Days 12
If less than one day hr. min.

9. Birthplace Macon Co. Mo.
(City or town, or county) (State or foreign country)

10. Usual occupation Farming

11. Industry or business

12. Name Delbert O. Krawel

13. Birthplace Adair Co. Mo.
(City or town, or county) (State or foreign country)

14. Maiden name Ada Muck

15. Birthplace Adair Co. Mo.
(City, town, or county) (State or foreign country)

PHYSICIAN

Major findings: NO

Of operations.....

Of autopsy.....

Underline the cause of which death should be charged statistically.

16. (a) Informant Leonard Krawel

(b) Address Atlanta Mo.

17. (a) Burial (b) Date thereof 1-5-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Quonby Co. Adair

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) Accident

(b) Date of occurrence 12-31-47

(c) Where did injury occur? Atlanta Mo
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? on public highway
While at work (Specify type of place)

23. Signature A. E. Edwards (S.P.D. or other) 1/1/48

Address Review Mo. Date signed.....

18. (a) Signature of funeral director Stephen Hooding

(b) Address Macon Mo.

19. (a) 1-17-48 (b) Mo O. B. Coffey
(Date received local registrar) (Registrar's signature)

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

MOTHER FATHER

FEB 2 - 1948

MAR 23 1948

RECEIVED
District Health Officer No. 15
District File Number 1:48-120
JAN 20 1948
Date Filed

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

O. L. Stephens

Licensed Embalmer No.

3057

P. O. Address

Merion, 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.

Registration District No. 201 Primary Registration District No. 5735-

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

1. PLACE OF DEATH:
 (a) County Macon
 (b) City or town Jackson Twp Rural
(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 years, months or days)

2. USUAL RESIDENCE OF DECEASED:
 (a) State MO (b) County Macon
 (c) City or town Jackson Twp Rural
(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 Orva Krawl
 3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month _____ Year 1947 hour _____ minute _____ M.
21. I hereby certify that I attended the deceased from _____, 19____;
 that I last saw him/her alive on _____, 19____;
 and that death occurred on the date and hour stated above.
 Immediate cause of death _____

4. Sex M 5. Color or race W 6. (a) Single, widowed, married, divorced M
 6. (b) Name of husband or wife _____ 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased July 19 (Month) 19 (Day) 19 (Year)
 8. AGE: Years 39 Months _____ Days _____ (Less than one day) _____ hr. _____ min.

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 10. Usual occupation _____
 11. Industry or business _____
 12. Name _____
 13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
 14. Maiden name _____
 15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant _____ (b) Address _____
 17. (a) _____ (b) Date thereof _____ (Month) (Day) (Year)
(Burial, cremation, or removal)
 (c) Place: burial or cremation _____
 18. (a) Signature of funeral director _____ (b) Address _____
 19. (a) _____ (b) _____
(Date received local registrar) (Registrar's signature)

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?

(Specify type of place)
 While at work? _____ (e) Means of injury _____
 23. Signature _____ (M. D. or other) _____
 Address _____ Date signed _____

SUPPLEMENTARY

MOTHER FATHER

PHYSICIAN

 Underline the cause to which death should be charged statistically.

S-44483