

FILED MAY 7 1948

Registration District No.

Primary Registration District No. **3000**

Registrar's No. **138**

1. PLACE OF DEATH:

(a) County **Adair**
(b) City or town **Kirksville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution
(Home) 314 S. Elson St
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution
16 yrs
In this community **16 yrs**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Adair**
(c) City or town **Kirksville**
(If outside city or town limits, write "RURAL")
(d) Street No. **314 S. Elson**
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **Joseph Crist**

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

4. Sex **m** 5. Color or race **w** 6. (a) Single, widowed, married, divorced **married**
6. (b) Name of husband or wife **Low Crist** 6. (c) Age of husband or wife if alive **89** years
7. Birth date of deceased **April 30 1862**
(Month) (Day) (Year)

8. AGE: Years **85** Months **11** Days **29** If less than one day hr. min.

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

10. Usual occupation **retired merchant**

11. Industry or business

12. Name **Samuel Crist**

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

14. Maiden name **Mary Scatter**

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

16. (a) Informant **Christine B. Hulse**

(b) Address **Kirksville, Mo.**

17. (a) **Burial** (b) Date thereof **5-2-48**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Memorial Cemetery**

18. (a) Signature of funeral director **Samuel P. Powell**

(b) Address **Kirksville, Mo.**

19. (a) **4-30-48** (b) **Walter Lambert**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **April** day **29th**
year **1948** hour **11:00** minute **55**

21. I hereby certify that I attended the deceased from **May 17th**
1948 to **April 29th**, 19**48**
that I last saw him **im** alive on **April 29th**, 19**48**
and that death occurred on the date and hour stated above.

Immediate cause of death **Serility**
Duration **11 1/2 mo.**

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? Means of injury.....

23. Signature **M. Sue Beards** (M.D. or other) **DO**

Address **Kirksville, Mo.** Date signed **April 30 1948**

PHYSICIAN

Underline the cause of which death should be charged statistically.

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

MOTHER: FATHER:

RECEIVED
District Health Officer No. 10
District File Number 2-48-79
Date Filed MAY -5 1948

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.....
James J. Taylor....., Registered Apprentice No. 436
working under my personal supervision.

Signed.....Robert B. Davis.....
Licensed Embalmer No. 4219
P. O. Address.....Kirkville 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.