S. No. 2
M-5-43
5-17-39
X36671

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

FILED APR 19 1948

Registration District No. 290

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 4427

13673

State File No.

Registrar's No. 43

1. PLACE OF DEATH:

(a) County Pulaski

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

(c) Name of hospital or institution: Waynesville General
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution 6 1/2 hrs. (Specify whether

In this community
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Pulaski 85

(c) City or town Swedesburg 0
(If outside city or town limits, write "RURAL")

(d) Street No. 0
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)

If yes, name country

3. (a) PRINT FULL NAME Wm. Jackson Cruzan

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 Widowed

6. (b) Name of husband or wife Josephine Lash Cruzan

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

7. Birth date of deceased Feb. (Month) 12 (Day) 1860 (Year)

8. AGE: Years 88 | Months 1 | Days 7 | If less than one day hr. min.

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

10. Usual occupation Retired

11. Industry or business

FATHER
12. Name R. R. Cruzan
13. Birthplace (City, town, or county) Indiana (State or foreign country)

MOTHER
14. Maiden name Elizabeth Sams
15. Birthplace (City, town, or county) Indiana (State or foreign country)

16. (a) Informant Mrs. Birnie
(b) Address Swedeborg, Missouri

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 3-22-48 (Month) (Day) (Year)
(c) Place: burial or cremation St. Johns Cemetery

18. (a) Signature of funeral director J. L. Hoops & Sons
(b) Address Crocker, Missouri

19. (a) 4-13-48 (Date received local registrar) (b) Thelma C. Buchthayer (Registrar's signature)

MEDICAL CERTIFICATION

20. **DATE OF DEATH:** Month March day 19
year 1948 hour 5 minute 35 p.M.

21. I hereby certify that I attended the deceased from Mar 19, '48 at 9 A.M., 19, to same day, 19;
that I last saw him alive on March 19, 1948;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac failure	3 day
Due to: Intestinal obstruction	3 day
Due to	
Other conditions: None positive (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

122B

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? (Specify type of place)
While at work? (e) Means of injury 0

ADDITIONAL SUPPLEMENTARY INFORMATION REQUESTED

23. Signature Paul C. Roock M.D. (M. D. or other)
Address Richland, Mo Date signed 3/25/48

(Licensed Embalmer's Statement on Reverse Side)

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 Paul B. Hoop

Licensed Embalmer No. 3261

P. O. Address Waynesville, 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.

S. No. 21
M—3-45
I X43680

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

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 11 Mail
Registrar's No. 43

Registration District No. 290 Primary Registration District No. 4427

1. PLACE OF DEATH:
(a) County Pulaski
(b) City or town Waynesville
(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)
In this community

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town (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 Wm J. Cragan
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 Wid
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased Jul 12 (Month) (Day) 1864 (Year)
8. AGE: Years 88 Months Days If less than one day hr. min.
9. Birthplace Indiana (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
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) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month March Day 19 Year 1948 Hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ; that I last saw h alive on , 19 ; and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Due to Volvulus	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations 1228	
Of autopsy Not Permitted	

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? (Specify type of place)
While at work? (e) Means of injury

23. Signature Paul C. Rooke (M. D. ~~or other~~)
Address Richland, Mo. Date signed 9/23/48

SUPPLEMENTARY

S-13673